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• At-A-Glance Card	
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Greater Baltimore Medical Center
DEPARTMENT CHAIRMEN AND DIVISION HEADS

ANESTHESIOLOGY

Ext: 2202 Fax: 3241

Harold M. Goll, M.D.

DIAGNOSTIC RADIOLOGY

Ext: 2935 Fax: 2866
Diagnostic Radiology
Interventional Radiology
Neuroradiology
Special Imaging

H. Alexander Munitz, M.D.

Lee Goodman, M.D.
Charles Yim, M.D.
Henry Wang, M.D.
Barton M. Cockey, M.D.

EMERGENCY MEDICINE

Ext: 2525 Fax: 2526

Jeffrey Sternlicht, M.D.

FAMILY MEDICINE

410 771-9220 Fax: 410 771-9301

Robin Motter, D.O.

GYNECOLOGY

Ext: 2382 Fax: 8068
Gyn Oncology
Reproductive Endocrinology
Urogynecology

Francis Grumbine, M.D.

Francis C. Grumbine, M.D.
Eugene Katz, M.D.
Joan Blomquist, M.D.

MEDICINE

Ext: 2680 Fax: 6812
Cardiology
Dermatology
Endocrinology
Gastroenterology
Hematology
Infectious Disease
Internal Medicine
Medical Oncology
Nephrology
Neurology
Pulmonary Diseases
Rheumatology
Rehabilitation Medicine

Neal Friedlander, M.D.

Reed Riley, M.D.

James H. Mersey, M.D.
Niraj Jani, M.D.
John A. Nesbitt, III, M.D.
Charles A. Haile, M.D.
Alan Kimmel, M.D.
Paul Celano, M.D.
Jeffrey Posner, M.D.
A. Allan Genut, M.D.
George Bedon, M.D.
Howard W. Hauptman, M.D.

OPHTHALMOLOGY

Ext: 2196 Fax: 2646

C. Pat Wilkinson, M.D.

OTOLARYNGOLOGY-H&NS

410 821-5151 Fax: 410 561-5275
Oral Surgery
Dentistry

Brian Kaplan, M.D.

Julius Hyatt, D.D.S.
Charles Walowitz, D.D.S.

PATHOLOGY

Ext: 2257 Fax: 3016

Robert A. Palermo, M.D.

PEDIATRICS

Ext: 2780 Fax: 8083
Neonatology
Ambulatory Pediatrics
Peds ED/Inpatient

Timothy F. Doran, M.D.

Howard Birenbaum, M.D.
John A. Boscia, M.D.
Melissa Sparrow, M.D.

PSYCHIATRY

443 849-2368 Fax 2248

Darin Lerner, M.D.

RADIATION ONCOLOGY

Ext: 2540 Fax: 2595

Robert K. Brookland, M.D.

SURGERY

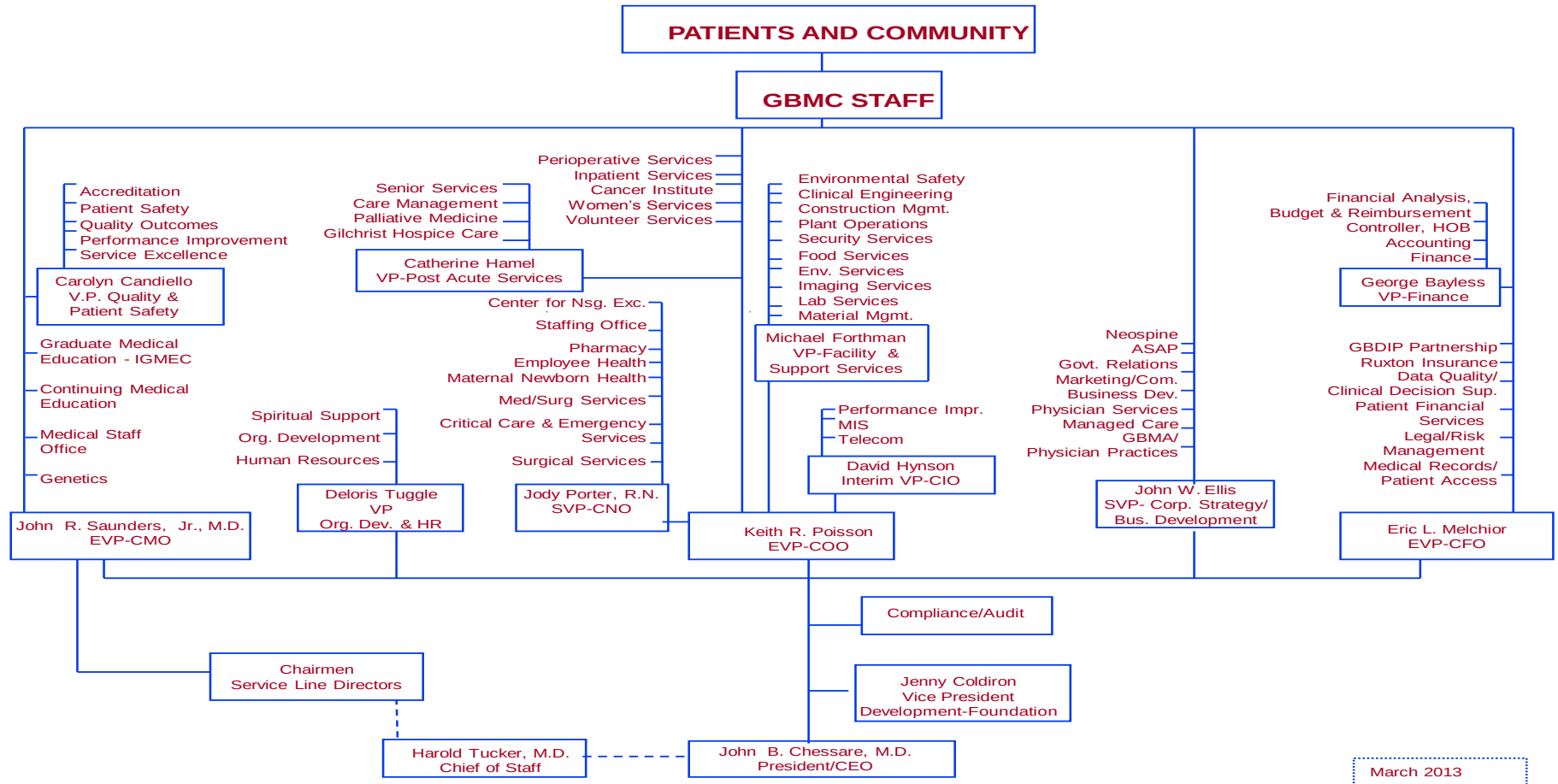
410 821-6260 410 821-7058
Colon/Rectal
General Surgery
Thoracic Surgery Section
Neurosurgery
Orthopedic Surgery
Pediatric Surgery
Plastic Surgery
Podiatry
Urology
Vascular Surgery

Jack Flowers, M.D.

George Apostolides, M.D.
Francis Rotolo, M.D.
Neri Cohen, M.D.
Reginald J. Davis, M.D.
Michael Scheerer, M.D.
James R. Buck, M.D.
William Crawley, M.D.
Victor Tritto, D.P.M.
Ronald Tutrone Jr., M.D.
Peter Mackrell, M.D. (Acting)

Note: Phone/Fax extensions are preceded by "443-849" if calling from outside, unless otherwise specified.

MANAGEMENT ORGANIZATIONAL CHART – GBMC



Management Organizational Chart: GBMC HealthCare

**Departments of Clinical Engineering,
Emergency Management, Safety & Security**

Department of Clinical Engineering

For Clinical Engineering Support (Clinical Equipment)

Director, Dan Tesch

(443) 849-2966 (24x7)

Area of Responsibility:

Critical Care Monitors

Anesthesia Gas Systems

Imaging Systems

Radiological Treatment Systems

Interventional / Cathlab / Endovascular Lab

Ventilators

Defibs

Nursecall Systems

Patient Beds, Wheelchairs and Stretchers

Patient Lifting System

Misc. other Clinical Devices

Department of Emergency Operation

(443) 849-3036, Director, Dan Tesch

Emergency and Safety Program Specialist, Michelle Tauson

Emergency and Safety Support Secretary, Donnie Dietz

Area of Responsibility:

Hazmat / WMD / Terrorist Incident Training and Resources

GBMC Hazmat / Decon Team Coordinator

Disaster / Critical Incident Committee

Note – During a Disaster event you are to follow the GBMC Emergency Operation Plan

Department of Life Safety

Director, Safety Officer, Dan Tesch

Emergency and Safety Program Specialist, Michelle Tauson

Emergency and Safety Support Secretary, Donnie Dietz

(443) 849-3036 Monday-Friday

(443) 849-2222 (**Security**) all other Times.

Areas of Responsibility:

Safety / EOC Committee

Fire Safety

MSDS Compliance

Environment of Care Issues

Department of Security/Protection

Director, Safety Officer, Dan Tesch (443) 849-2090

Main Security # 24x7 = (443) 849-2222

Note – For Critical Safety Issues you are to follow your departments Safety / Fire / Disaster plans. Security is to be notified of hazardous situations by calling ext 2222. Security Personnel are available at this extension 24 x 7.

GBMC HEALTHCARE
DEPARTMENT OF INFORMATION SYSTEMS

Computing Resource Guide for New Physicians

Quick Start / Resources at a Glance

More in-depth information can be found on subsequent pages.

MIS Help Desk

Call 443-849-3725 anytime for live phone help with questions or problems related to GBMC's computing and telecommunication resources.

The CPOE Helpline, 443-849-2200 is available 24/7 for any order entry questions or problems.

Obtaining Access to the System

All physician requests for access should be directed to the Medical Staff Office for review, 443-849-2370.

Quick Reference Guides

For experienced computer users, quick brochure-style reference guides are available for both Meditech and PACS. A logon guide and a more comprehensive user's manual are also available for Meditech. These materials can be obtained by contacting the Medical Staff Office, Physician Relations (443-849-6176), or the MIS Help Desk.

GBMC On The Web

From any PC that has Internet access, start Internet Explorer and type www.gbmc.org in the address box. Then click on the "Physician Portal" tab to access educational and research resources, link to Meditech remotely, or learn more about physician services and the medical library.

Obtaining Access to the System

There are three types of system access for physicians at GBMC. Depending on whether you are employed by the hospital or not, and where you wish to view patient information, you may need any or all of the following types of access:

- **Meditech Logon** – This is used to access order entry, patient data, reports, and radiographic images in the Meditech software system (see below). Once you have requested and received access to Meditech, your user ID will be the same as your five-digit dictation number (also assigned to you by the Medical Staff Office).

Please note that Computer Provider Order Entry (CPOE) access will only be granted after the provider attends a CPOE training class.

- **Novell Logon** – This is used to access system applications, such as email, on GBMC computers. Your username will be your first initial followed by all or part of your last name. For example, Dr. William Smith would be wsmith@gbmc.org, while Dr. Sandra Clementine might be sclement@gbmc.org (the last name being truncated in this case).

- Remote Access – This is required as part of CPOE. Any Internet connection will do, however a higher speed connection such as DSL or cable modem provides better performance and is necessary for adequate viewing of radiographic images. Requests for remote access are processed through the Medical Staff Office.

Accessing Patient Data via Meditech

1. Obtain a Meditech logon (see above).
2. Start the Meditech software by double clicking the Meditech icon. The icon looks like this



MEDITECH Greater Baltimore Medical Center.lnk

and can be found:

- On the desktop of GBMC computers throughout the hospital.
 - On the remote access desktop if you are using remote access.
3. Enter your five-digit dictation number in the USER field. Press Enter
 4. Enter your password in the PASSWORD field. Press Enter.
 5. The first time you logon to Meditech, and periodically thereafter, you will be required to change your password. Follow the on-screen instructions to enter and confirm a new password.
 6. The Meditech home screen (Physician Main Desktop) will now appear.
 7. For further instructions on using the Meditech software, several resources are available:
 - Contacting (443) 849-2200 for assistance and training
 - Meditech Logon Guide.
 - Quick Reference Brochure.
 - The MIS Help Desk.

Information on accessing these resources is listed in the Quick Start section above.

Accessing Radiographic Images via PACS

Patient radiographic images are now stored, and can be viewed, electronically via a system called PACS. To access and view an image for your patient, begin by viewing that patient's data in the Meditech system. Then click on the "Imaging" option on the right-hand menu. When the list of images appears, click on the camera icon on the far right to view the study of interest. This will start specialized software called LightView.

For more detailed instructions on accessing images and using the LightView software, the following resources are available:

- PACS Quick Reference Guide.
- MIS Help Desk.

Information on accessing these resources is listed in the Quick Start section above.

Accessing the System Remotely

1. Obtain a remote access logon (see above).
2. From any PC with Internet connection, go to the remote access web page by typing **<https://weblogin.gbmc.org>** in the address box.
3. 3. If the Citrix remote access software has never been installed on that PC, click on the "Download Citrix" link and follow the instructions. This software only needs to be installed once per PC. If you are not sure, there is no harm in repeated installations.
4. Enter your user name and password, then click the "Log In" button.
5. 5. Depending on your type of remote access, you will either see a Meditech icon or a desktop icon. Click the icon. Once you see a Meditech icon, click on it and the Meditech software will appear. Then logon to Meditech as above.

6. Detailed instructions on using remote access are available and can be obtained by:
- Contacting the Medical Staff office.
 - Contacting the MIS Help Desk.
 - Following the link on the Info web.

Information on accessing these resources is listed in the Quick Start section above.

Contact Information

MIS Help Desk: 443-849-3725 anytime.

CPOE Helpline: 443-849-2200 anytime.

Medical Staff Office: 443-849-2370 weekdays 8:30AM to 5:00PM.

The Hospitalist Group at GBMC

Introduction

The Hospitalist Group at GBMC is a dedicated practice of internal medicine physicians specializing exclusively in the care of the hospitalized patient. The practice at GBMC consists of ABIM board certified/board eligible physicians. Collectively, GBMC hospitalists provide care in the hospital 24 hours a day, every day of the year.

Since its inception in 2007, the Hospitalist Group at GBMC has emerged as one of the longest successfully running hospitalist models in Baltimore. The practice is proud to have developed longstanding relationships with all physician groups at this institution. GBMC hospitalists take care of a large percentage of medical patients admitted in all areas of acuity: general medicine, med/psych, oncology, telemetry, and intermediate care unit. Hospitalists are further involved in emergent/urgent care, as part of GBMC's Rapid Response Team. Beyond this, the hospitalists provide consultation services to any admitting physician (on request) at GBMC, and frequently co-manage the care of surgical, gynecologic, and orthopedic inpatients. The group is available to physicians using the Sherwood Surgical Center as well, in case of acute medical consultation. As hospitalists, these physicians are also well trained in the discharge needs of inpatients. Ultimately, the hospitalist group at GBMC offers comprehensive medical care to any patient at the request of the referring physician.

Contact Numbers

- Hospitalist pager numbers can easily be accessed in Meditech by clicking on the picture of the "World" with an "R" in front of it (Reference Links Icon) in the lower right and then choosing "Patient List-Hospitalist."
- To reach a specific member of the group, each hospitalist has a personal pager. These numbers are easily available through the hospital operator, or Meditech, and are clearly listed on each hospital unit.
- The Hospitalist Group Office Manager is Mrs. Penny Tognocchi, available at (443) 849-8046.
- Hospitalist Fax: (443) 849-8057.

Location

- The Hospitalist Office at GBMC is located on the main floor of the hospital in Suite 3808.

Miscellaneous

- A daily contact list of hospitalists caring for a specific patient is faxed to each hospital floor.
- Hospitalists can see patients in any inpatient unit of the hospital, as well as the PACU, Sherwood Surgical Center, and the Wound Care Center.

02/25/13

Inpatient Mid-Level Team Services

A dedicated mid-level team is available to provide on-site support for community physicians who choose to manage their patients' hospitalizations.

Inpatient Attention While You Stay in the Office

The team is available for care when you most need to be available at your office practice. This service, designed to assist you in caring for your patients when they are hospitalized, is available 24/7 by calling 443-849-7925. You can request on-site hospital care for a patient arriving via direct admission or through the emergency service. As a reminder when calling, please leave your pager number.

Services Provided

The team's specific role is to:

- ❑ Manage patient care in conjunction with the attending physician once the patient has arrived on a hospital unit either from the emergency department or directly from your office.
- ❑ Provide on-site coverage and communication with the admitting physician on non-urgent treatment changes.
- ❑ Consult regularly with the nursing team on the day-to-day care provided to the patient – ensuring that treatment regimes have been delivered as expected.
- ❑ Interface with specialty consults and ancillary testing.

Imaging Services at Greater Baltimore Medical Center

Services Offered

CT Scanning- Offers an array of procedures including cardiac scanning and virtual colonoscopy, and biopsies. Offer 3D rendering of images to aid in diagnosis and treatment. Services are provided to outpatients, inpatients and emergency room patients

Diagnostic Radiology- Offers an array of routine x-ray services for outpatient, inpatient and emergency room patients. Offers fluoroscopy, arthrograms and plain film procedures

DEXA Services- Offers services that measure bone density

Interventional Radiology- Many invasive diagnostic and therapeutic procedures performed that are tailored to meet the needs of the individual patient. Procedures include angioplasty, fallopian tube recanalization, vascular stenting, biopsies, chemoembolization, vascular access procedures, vertebroplasties, kyphoplasty, diagnostic angiography, embolization, ablation techniques, IVC filters, venous samplings and more. All patients receive a consultation for a detailed explanation and to answer any questions. Services are provided on an outpatient and inpatient basis.

MRI- Offers an array of procedures used to evaluate head, neck, thorax, abdomen, spine and extremities. In addition, MRA (Magnetic Resonance Angiography) and Breast Biopsy Procedures are performed. Services are provided to outpatients, inpatients, and emergency room patients.

Nuclear Medicine- Offers an array of procedures that include myocardial perfusion, bone, lung, renal, and gastric studies. Services are provided to outpatients, inpatients, and emergency room patients.

PET/CT- Offers an array of exams useful in the detection of cancer and evaluating degenerative conditions, such as Alzheimer's disease and cardiac viability. Services are provided to outpatients, and inpatients.

Ultrasound- Offers an array of procedures specializing in echocardiography, vascular and general diagnostic ultrasound. Services are provided to outpatients, inpatients and emergency room patients.

Location of Services

Services located on Level III :

- Diagnostic Radiology
- CT Scanning
- General Ultrasound
- Interventional Radiology

Upon entering hospital grounds, follow 'Radiology Services ' signs to Garage D. Follow signs to main lobby. Register at the main lobby. Patients will be escorted to Radiology.

Services located on Level I

- Echocardiography Ultrasound
- Nuclear Medicine
- Vascular Ultrasound
- MRI
- PET/CT

Upon entering hospital bear left and make your 1st right into parking lot C. If scheduled for MRI or PET/CT, upon entering parking lot C turn right and follow signs.

Hours of Operation for Outpatient Services

CT Scanning.....	7:30am – 5pm Monday- Friday.
Diagnostic Radiology.....	7:30am- 4pm Monday – Friday.
Interventional Radiology	8am- 4pm Monday-Friday.
Ultrasound (Echo, General, Vascular).....	7:30am- 5pm Monday- Friday.
MRI	7:30am- 8pm Monday- Friday
	9:00am- 12:30pm Saturday
PET/CT	8am- 3:30pm Monday- Friday

Scheduling an Outpatient Exam

Patient services assistants are available to schedule appointments from 8am- 5pm. Monday –Friday.

To schedule an appointment call:

Diagnostic Radiology	443-849-2320
CT, Ultrasound, or Nuclear Medicine	443-849-2343
Interventional Radiology	443-849-2311
PET /CT or MRI.....	410-580-2330
Oncology Imaging and Interventional Center.....	443-849-2020

Radiology Final Reports

Diagnostic Radiology
CT Scanning
Nuclear Medicine
Ultrasound (Echo, General, Vascular)

Diagnostic, CT, Nuclear Medicine and General Ultrasound final reports will be faxed to your office within 24 hours. Echo and Vascular reports will be faxed within 48 hours. If you wish to speak with a radiologist regarding a radiology stat report during normal business hours, call 443-849-2922. If you need to obtain a copy of a report, call Imaging Library @ 443-849-2325 or call 443-849-2343, listen to prompt for Radiology reports.

Interventional Radiology

Final reports will be faxed to your office. If the findings require immediate intervention an Interventional Radiologist will call the referring physician. If you wish to speak with an Interventional Radiologist, call 443- 849-2311 during normal business hours.

MRI & PET/CT

Final reports will be faxed to your office within 24 hours. If you wish to speak with a radiologist, call 410-580-2331.

Access to Images (PACS)

If you have privileges at GBMC you can gain access to your patients' medical images from most any personal computer. Images can be accessed through the Meditech EMR. If you require access to Meditech contact the help desk at 443-849-3725. A PACS Quick Reference Guide is available at the Imaging library in our Radiology Department.

Radiologist Coverage / Availability

Radiologists are available in the hospital from 8am to 7pm Monday through Friday, and 8am to 6pm on weekends and holidays. A Radiologist reads GBMC Stat studies from a remote location after the radiologist has left the hospital. Preliminary reports are faxed to the ordering physician. A radiologist is on call each night. To contact a radiologist on call, call 443-849-3950.

If you have any questions or concerns please contact Radiology Administrative Assistant Patricia Miller at 443 849 2935 or e-mail, plmiller@gbmc.org.

Key Radiologist Contacts

H. Alexander Munitz, MD
Chairman, Department of Radiology
443-849-2935

Barton Cockey, MD
Medical Director
Nuclear Medicine & Vascular Ultrasound
443-849-2922

Russell Gelman, MD
Medical Director
Diagnostic Ultrasound
443-849-2922

Shu Li, MD
Medical Director
Cat Scan
443-849-2922

Charles Yim, MD
Medical Director
Interventional Radiology
443-849-2311

Lee Goodman, MD
Medical Director
Diagnostic Radiology
443-849-2922

Loralie Ma, MD, Ph.D.
Medical Director
Medical Imaging of Baltimore
410-580-2331

Key Radiology Administrative Contacts

Philip J. Komenda
Administrative Director
443-849-2324

Barbara Nagle Bodyk
PACS Administrator
443-849-2945

Carole McCreadie
Scheduling Supervisor
443-849-2320

Cindi Kendrick
Facility Manager
Medical Imaging of Baltimore (MRI & PET/CT)
410-296-5610

Frequently Asked Questions

1. What information does the patient's/physician's office need to schedule an appointment?

Patient's full name and date of birth, type of test, insurance information. It is helpful if patient has prescription/ physician order when calling.

2. How long does it generally take to come in for an Imaging Exam depending on whether you need prep prior to your exam? The following times apply:

Modality	stat	outpatient		stat	Inpatient	
		urgent	routine		urgent	routine
Nuc Med	Same day	1 day	7 days	1.5 hr	8 hrs	24 hrs
Ultrasound	same day	1 day	7 days	1.5 hr	8 hrs	24 hrs
CT	same day	1 day	7 days	1.5 hr	8 hrs	24 hrs
Diag Rad	same day	1 day	7 days	1.5 hr	8 hrs	24 hrs
Interv Rad	same day	1 day	7 days	1.5 hr	8 hrs	24 hrs
MRI	same day within	1 day	7 days	1.5 hr	8 hrs	24 hrs
PET/CT	24 hrs	1 day	7 days	1.5 hr	8 hrs	24 hrs

3. Can I schedule my appointment online?

Yes, go to www.gbmc.org click on services, full list of services, alphabetical list of services, Radiology, click icon "request an appointment" in the middle of the page and complete online form. Someone from our scheduling team will contact you within 24 hours

4. How is patient informed about prep?

Scheduler will provide patient with prep instructions.

5. Should patient arrive early for test?

Yes, Patient should arrive 15 minutes before appointment time unless otherwise directed.

6. What does patient need to bring on arrival for appointment?

Prescription/ physician order, insurance card, photo ID.

7. How long does the test take?

This depends on the test and can range from five minutes to three hours. The Radiology scheduler should be able to tell you how long your test will take.

8. When and how do we get test results?

The Radiology Department will send your results to your physician within 24-48 hrs after your test has been completed. Patients should be instructed to call the physician's office. Physicians' offices can call Imaging library at 443-849-2325 for results or call x2343 and listen to prompt.

9. If a patient wants copies of images whom does he/she call?

Patients can request copies of images by calling the Imaging Library at 443-849-2325. Images can be copied to disk and made available to the patient or referring physician.

10. Who should we call to schedule a biopsy?

All Radiology biopsy procedures are scheduled by calling 443-849-2311.

Procedures for Obtaining MRI Reports on Inpatients at GBMC
From GBMC MRI and PET/CT Center

From 7:30 a.m. to 4 p.m., Monday through Friday: MRI's are read by a radiologist and reports are typed until approximately 4 p.m. Preliminary reports are faxed to the Unit (Check with the Unit Clerk) The final signed report will be scanned into the EMR. Remember-- a radiologist is at the center until 4 p.m. to discuss the results of any test.

From 4 p.m. to 10p.m. Monday through Friday: If the report is not on the floor or in EMR, call 410-580-2331for report .After 10pm call 1 866 941 5695 for report.

Saturday: 7am- 2pm: Call 410-580-2331for report. Between 2pm- 6pm, if the report is not on the floor or in the EMR, call 410-377-1590. After 6pm call 1-866-941-5695.

Saturday: 7am- 2pm: Call 410 580 2331for report. Between 2pm- 6pm, if the report is not on the floor or in the EMR, call 410 377 1590. After 6pm call 1-866-941-5695.

Sunday: The center is available for emergencies only. Between 7am -6pm , if the report is not available on the floor or in the EMR, call 410 377 1590 for report. After 6pm call 1 866 941 5695

REMEMBER: The verbal or faxed reports obtained on nights and weekends are preliminary.

Finally, a report on a MRI obtained on a STAT basis (e.g. suspected cord compression), will be read on a 24/7 basis.

John E. Savage Medical Library at GBMC

Main Hospital Lobby

6701 N. Charles Street

Baltimore, MD 21204

Phone: 443-849-2530

Fax: 443-849-2664

Website: <http://infoweb/body.cfm?id=124> (inside hospital)

Website: <http://www.gbmc.org/medicallibrary> (outside hospital: call for a password)

Staff: Deborah A. Thomas, MLS - Library Director dathomas@gbmc.org

Dianne Deck - Library Coordinator library@gbmc.org

Staffed hours: Mon. - Fri. 8:00am - 4:30pm (for after hours access, contact us 443-849-2531)

Services available to attending physicians:

- Journal articles free of charge (emailed, faxed or mailed)
- ACOG article sets
- Literature searches
- Book ordering
- ClinicalKey search engine (call 443-849-2530 for a personal password)
- Library purchase recommendations gladly accepted
- Laptop sign-out for hospital use
- 13 Internet-connected PC's for your use
- Meeting room use

Medication Reconciliation

JCAHO Patient Safety Goal requires organizations to reconcile medications across the continuum of care accurately and completely by developing a process for obtaining a complete list of each patient's current medications.

What is meant by completely reconcile?

Process of comparing what the patient is taking at the time of admission or entry into a new setting with what the organization is providing. The goal supports improved patient safety by:

- Avoiding transcription errors
- Avoiding omission
- Avoid duplication of therapy
- Avoiding drug-drug or disease-disease interactions

What medications have to be reconciled?

- Prescription medications
- Sample medications
- Herbal remedies
- Vitamins
- Over-the-counter drugs
- Vaccines
- Diagnostic and contrast agents
- Radioactive medications
- Respiratory treatments
- Parenteral nutrition
- Blood derivatives
- IV solutions

What will be required of me?

- Outpatient visits: review and update home medication list with patient
- On admission: compare all prescribed medications with those on home list of medications
- On change in level of care: review all prescribed medications and compare with home list of medications
- On discharge/transfer: review medication and compare with home list prior to discharge, document changes and communicate to the next provider of care/service a complete list of medications prescribed

GBMC Healthcare - Department of Health Information Management

The Physician ID number assigned to you is also your Medical Record ID number.

Physician's Record Office (Pro*Shop) – 443-849-2277

The Physician's Record Office (PRO*Shop) is located on the 3rd floor across the hall from the Executive Offices in Suite 3247. The PRO*Shop has five workstations equipped with a PC and telephone for physician use. The PRO*Shop is daily from 7:00 a.m. – 9:00 p.m.

Accessing Medical Records for Patient Care

Medical records for patients seen from August 1, 1996 to present are available in the EMR (Electronic Medical Record) in Meditech. Please contact the PRO*Shop (ext.2277) for access to records prior to August 1, 1996.

Accessing Medical Records for Studies or Research

Research studies must be accompanied by written approval from the IRB. Please contact the Medical Staff Office at (ext 2370).

Completion of Records

Medical records of each discharged patient must be completed within 30 days following discharge. Records are evaluated for signatures on dictated reports and for the presence of a Discharge Summary on stays longer than 48 hours, a Discharge Note on stays less than 48 hours, and for a dictated operative report on surgical patients.

Health Information Management Department will fax a letter listing deficient medical records 21 days post discharge. You will receive a notification via fax containing the information on the medical records you need to complete. Failure to complete medical records within 30 days post discharge will result in Administrative Action. The names of physicians on Administrative Action will be sent to the Executive Management, that include the Executive Vice President and Chief Medical Officer, Chief of Staff, Director of Performance Improvement and Clinical Chairmen.

Failure to complete delinquent medical records within 60 days post discharge will result in suspension of clinical privileges. Failure to complete delinquent medical records within 90 days post discharge will result in automatic revocation of medical staff membership and clinical privileges.

Dictation/Transcription

Health Information Management provides transcription services for the reports of GBMC patients who were treated for an inpatient admission, same day surgery or emergency department visit. You will receive copies of each of your dictated reports via fax.

When dictating always state the following:

- Your name
- The attending physician/physician you're dictating for (when applicable)
- The patient's name
- The eight-digit medical record number
- The date of admission/discharge
- The spelling of physician name to whom copies of reports are to be sent (include the complete address for physicians not on staff at GBMC)

Transfer Summaries must be dictated as a work type 7 to ensure these reports are given priority and are available at the time of the patient's transfer.

Dictation Instructions

To access the dictation system, dial extension 2883 (outside the hospital call 443-849-2883).

After the announcement, enter your personal five-digit ID number (if your ID# is less than five digits, enter zeroes before your number to create a five-digit ID#), the two-digit work type number and the eight-digit patient medical record number.

The work types are as follows:

WORK TYPE NUMBERS

- | | |
|-------------------------|--------------------------|
| 1. Discharge Summary | 6. Admission Note |
| 2. Operative Report | 7. Stat Transfer Summary |
| 3. Consultation | 8. Priority Consultation |
| 4. ER Admission Note | 9. ER Note |
| 5. History and Physical | 10. Interim Summary |

Because the system has built-in VOR (Voice Operated Record), you may begin your dictation and the recorder will automatically start recording. When you stop talking or pause, the recorder will automatically stop and the low continuous tone will return.

The touch-tone commands are as follows:

1. Listen
2. Dictate (VOR Operation)
3. Rewind (will rewind approximately 15 words and then automatically begin playback).
4. Pause – (you can pause for approximately 2 minutes before being disconnected)

5. End of Document. (This separates your reports. Touch this after each report to re-enter your personal ID number; then enter the new work type number, patient number and begin dictation.)
6. Go to End of Dictation. (After touching this, the recorder will instantly place you at the end of your dictation. You may then begin dictating.)
7. Fast Forward. (After touching this key, the recorder will fast forward and stop at the end of your dictation.)
8. Go to Beginning of Dictation. (The recorder will instantly place you at the beginning of the document being dictated. Touch “1” to listen. Touch “2” to dictate.)
9. Manual Disconnect. (Depress this key before hanging up).

Multiple Dictations – To dictate multiple reports, depress “5.” This re-enters your personal five-digit ID number, then enter the work type number and patient ID number.

Verbal Insertion - Rewind to the point where the passage is to be inserted. Depress “#” and “6”, then dictate the insertion. To exit the insert mode, press “3”.

Formats for Dictation

Discharge Summary - dictate at time of discharge (work type 1 for routine, work type 7 for STAT or Transfer Summary)

- Admission and discharge dates
- Principal Diagnosis (that diagnosis which was determined have study to have caused the admission)
- Brief reason for admission and HPI
- Significant physical findings
- Significant test results from this visit
- BRIEF hospital course/treatment rendered
- Procedures performed
- Discharge destination (i.e. home)
- Discharge instructions

Operative Report – dictated immediately after procedure (work type 2)

- Date of surgery
- Primary surgeon
- Assistant surgeon(s) and/or residents
- Anesthesiologist
- Pre-operative diagnosis
- Post-operative diagnosis
- Anesthesia used
- Blood loss/blood replaced
- Specimens removed
- Complications and drains
- Detailed description of technical procedure used
- Condition at conclusion of procedure

History & Physical – completed within 24 hours of admission (work type 5)

- Chief complaint
- History of present illness
- Past medical and/or surgical history
- Medications/Allergies
- Review of systems
- Physical exam: HEENT, Neck, Chest, Abdomen, GI, GU, Extremities, Neuro
- Assessment/diagnostic impression
- Plan of care/treatment recommendations

Admission Note – completed within 24 hours of admission (work type 6)

See History & Physical Format

Consultations – (work type 3)

- Date consultation is performed
- Name of physician requesting consult
- Reason for consultation
- Past medical history
- Physical examination of patient
- Assessment/diagnostic impression
- Plan of care/treatment recommendations

Data Quality/Coding Office – 443-849-3509

The basic role of the coder is to translate what the physician has documented on his patient's record into ICD9cm and CPT codes. Coders can only code what is stated explicitly and not what is implied. This is the reason why physicians are queried retrospectively regarding diagnoses, which they alluded to but did not state. An example of this is "Patient had surgery, lost 1100ccs of blood, transfused 2 units for a hematocrit of 24." It is obvious to the coder that the patient has blood loss anemia, but unless the physician uses those very words, this diagnosis cannot be coded. The following are examples of common documentation issues coders encounter frequently, which result in either a Coder Physician Query or an incomplete patient profile:

Acute Myocardial Infarction: State the site and whether or not it is subendocardial or involves the full thickness of heart.

Sepsis: If patient has this condition, use this terminology. Urosepsis is translated into a UTI in ICD9cm; bacteremia is considered the presence of bacteria in the blood.

Pneumonia: Be as specific about the cause of the pneumonia as you can. If you are treating the patient for a suspected organism, state this. If patient is being treated for aspiration pneumonia, please document.

Abnormal finding: Document all lab findings, which are treated or monitored. Coders cannot code from lab reports. If you consider the finding to be significant, please document.

Anemia, thrombocytopenia and leukopenia: Please document etiology, if known.

Diabetes Mellitus: Please distinguish between Type I and Type II diabetes. Coders can no longer use the terms IDDM or juvenile or adult onset diabetes. Also state all manifestations of the diabetes and whether or not the diabetes is controlled or uncontrolled.

Wound Debridements: Please set the level of debridement; e.g., skin, muscle, bone.

Open Wound: There is no code for “open wound” Please specify the etiology of the wound.e.g. skin ulcer or injury.

Fracture: If the fracture is not the result of trauma, please state spontaneous or pathological.

Chest Pain: Please state the known or suspected etiology at the time of discharge.

Mental Status Changes: Please state the known or suspected etiology at the time of discharge.

Renal Failure/Insufficiency; Coders frequently find that renal failure and renal insufficiency are used interchangeably in the same patients chart. The conditions have different codes, which have different impacts on patient severity. Please clarify whether patient has renal failure or renal insufficiency.

Arrhythmia’s: Please be as specific as possible. If the patient has Paroxysmal SVT, please state rather than SVT.

Frequently missed diagnoses: The following are diagnoses, which frequently exist and meet criteria for coding but are not documented.

Acute Renal Failure
Dehydration
CHF
Chronic Renal Failure
COPD
Hypotension
Hydronephrosis
Hypoxia
Morbid obesity
Respiratory failure
Valve disorders
Electrolyte disturbances

Present on admission;

It has become mandatory that hospitals report whether or not patients are admitted with certain diagnoses or these diagnoses occur during the hospital stay. This is part of a

national and state quality of care initiative and the correct reporting of these conditions will have a major effect on hospital “report cards” and also reimbursement. Conditions that are reported not present on admission can be considered HAC (Hospital Acquired Conditions) and reduce the reimbursement to the hospital for care. It is therefore very necessary to clearly document whether patients come in with certain conditions or the condition is acquired after the patient is admitted. Catheter infections and decubitus ulcers are examples of diagnoses which may be involved.

A final note: Please be as specific as you can be. This will help the hospital achieve an accurate profile of its case mix and help you avoid retrospective queries from coders. Document clearly in your discharge summary, the principal diagnosis (That diagnoses which is responsible for the admission to the hospital. Include all secondary diagnoses which affected care and management of the patient.



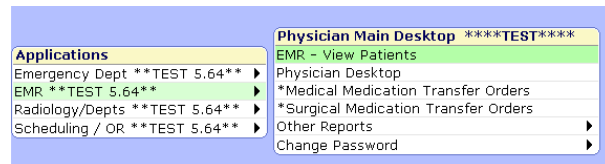
Meditech



Electronic Signature Quick Reference Guide

Signing and Rejecting Documents / Orders in Meditech

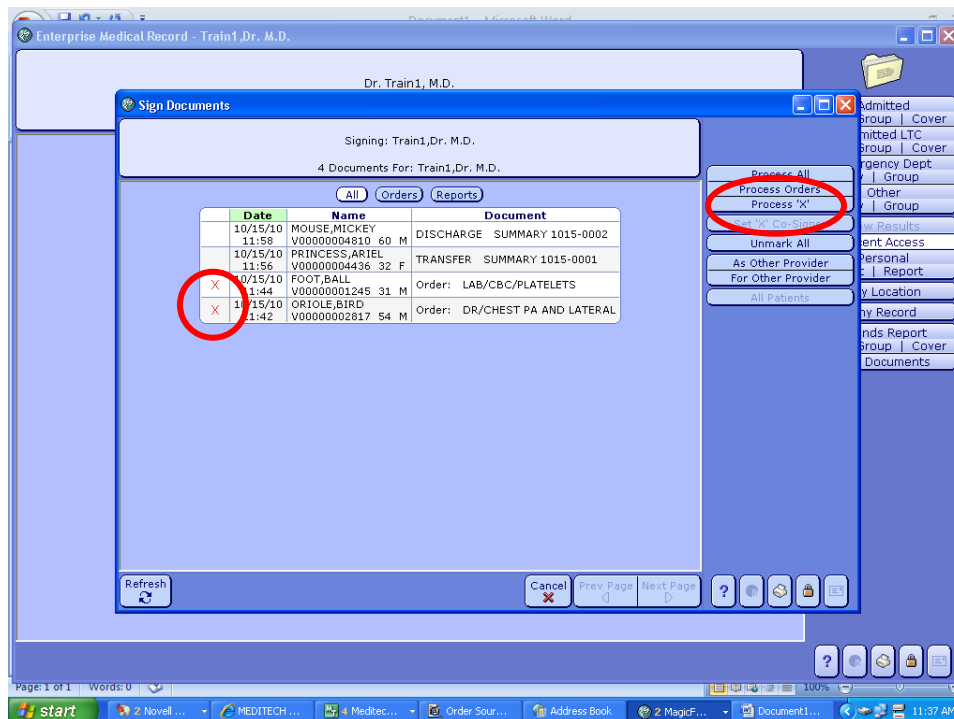
1. Sign into Meditech and click **EMR**.
2. Click **EMR – View Patients**



3. Click **Sign Documents** on the right hand menu.



- Single click in the left hand column next to each order(s) you wish to sign/reject. A **red "X"** will appear next to each one when you choose it.
- Click **Process "X"** on the right hand menu bar.



- TO SIGN:** The order details for the first order you chose will appear, click on the **Sign Icon**. The next order you chose will appear, again you must click the **Sign Icon**. Then a screen will appear: "2 orders selected for signature", choose **Sign** at the bottom of this screen. A screen will display that requires you to enter your Meditech password. After entering your password hit **Enter** on your keyboard and your orders are signed.
- TO REJECT:** Click the **Reject Icon**, enter the rejection reason from the drop-down menu, click **Reject** at bottom of the screen, and enter your Meditech password.



CONTINUED NEXT PAGE

1	2	3	4	5	6
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Patient: FOOT,BALL
Acct#: V00000001245
Unit#: M000000512
Reason for Visit: LOSER

Age/Sex: 31 M **DOB:**
Room-Bed: 4809-A **Location:** U48
Att Dr: Ross,Laurence H M.D.

Category: LABORATORY
Procedure: CBC/PLATELETS
Priority: R **Quantity:** 1
Status: Cancelled
Entered By: NURSE3 TRAINING

Ordered Date/Time: 10/15/10 1144
Service Date/Time: 10/15/10 1600
Ordering Dr: Train1,Dr. M.D.
Order#: 1015-0031

CBCP includes WBC,CWBC,RBC,HGB,HCT,MCV,MCH,MCHC,PLTS,RBCDW

Cancelled: Auto-cancelled after 1 day.

Signature Comments:

Order Num 1015-0031 Service Date/Time: 10/15/10 1600 Ordered by: Train1,Dr. M.

*Rejection Comment:

Not a CPOE Physician



GBMC PATIENT ACCESS

About Us:

Patient Access services include admissions, registration, upfront collections, patient information and other related services.

We provide services for various outpatient and inpatient areas throughout the hospital and are staffed with 75+ team members.

Patient Access Registration Areas:

- Antenatal Testing/OB Patient Access
- Anti-Coagulation Clinic/Special Imaging
- Diagnostic Center Lab
- Emergency Department
- Endoscopy
- General Operating Room (GOR)
- Main Patient Access
- Patient Information Desk
- Sherwood Surgical Center
- Women's Surgical Center

Admission & Direct Admission Requests:

Please contact the hospital Administrative Coordinator at x2076 or x2077 with admission and/or direct admission requests. If unavailable, he or she may be reached by using the hospital paging system. Dial (443) 849-3135 and enter beeper 406 and then your extension. Please contact the hospital operator if paging assistance is needed. Patients directly admitted to the hospital are asked to register at Main Patient Access (Main Lobby) between the hours of 7am and 11pm and after hours in the Emergency Department - with the exception of those patients being directly admitted to IMC/MICU/SICU. In those situations Patient Access will be notified of the need to register the patient at the bedside location. The Administrative Coordinators have provided additional and specific requirements regarding direct admit requests/orders. See also – Table of Contents “Daytime Direct Admissions” (pg. 97) & “Direct Late Admissions” (pg. 99).

Information and Services:

Contact information and references are available on our Info Web page:

<http://infoweb/body.cfm?id=183>

Other available information:

- Patient Financial Assistance contacts and information
- Patient Information and Registration Area Phone extensions
- Nursing Unit Phone Extensions and more....

Lab & Radiology Information:

- Please utilize your GBMC, LabCorp, or Quest lab requisition forms.
- Please also utilize the Lab & Radiology Insurance Reference Grids/tables (available on the Patient Access InfoWeb page) to determine participating lab and radiology facilities and/or referral requirement for your patients. See Patient Access InfoWeb page for References (L) – Lab Grid <http://infoweb/body.cfm?id=197> or References (R) – Radiology Grid <http://infoweb/body.cfm?id=202>
- Writing orders legibly will assist with identifying the correct order requests.
- A signature is required on all orders and requisitions.
- To avoid follow-up calls to your office, delays to the patient and billing issues, please include the diagnosis and all diagnosis code(s) associated with the patient's order.
- In the event that an ABN - Advanced Beneficiary Notice is generated, we will be calling your office to verify all codes and/or obtain additional codes.
- The e-Clinical-Works (eCW) application is currently being used at Greater Baltimore Medical Associates (GBMA) office locations to enter Lab/Radiology orders and receive results electronically.

Death Certificates:

Patient Access facilitates completion of death certificates. Between the hours of 9am until 9pm, Patient Access will notify the attending physician of any death certificates to be signed. Physicians have 24 hours to complete and sign the death certificate.

Please note, the attending or his/her designee is responsible for completing and signing the death certificate. Death certificates may be signed at Main Patient Access, located in the hospital main lobby, from 5:30a-11p and in the ER Patient Access registration area from 11p – 5:30a.

OB Patient Access (open 24/7), located on the 2nd floor of the main hospital, facilitates completion of death certificates as related to the following:

- Fetal Deaths
- Live Birth Deaths
- Any death of a infant admitted to the NBN or NICU

Other Death Certificate Reminders:

- Death certificates must be completed in black ink
- No corrections/scratch-outs are permitted
- "Cardiac Arrest" and "Respiratory Arrest" are not acceptable diagnoses per Vital Records.
- "Stillborn" and/or "pre-maturity" is not an acceptable cause of death.

GBMC

CLINICAL POLICY AND PROCEDURE

ABBREVIATIONS AND SYMBOLS

APPROVALS:

Signature on file
Chief of Staff

Signature on File
Sr. VP of Patient Care Services & CNO

I. PURPOSE

To assist in the delivery of health care to the patient that is dependent on written information and to avoid misinterpretation of medical record entries that may result in harm to the patient.

II. POLICY

The indiscriminate use of abbreviations is extremely dangerous. It is recommended that abbreviations should be used as little as possible.

III. PROCEDURE

- A. Medical Abbreviations (most recent addition), by Neil M. Davis, is the approved reference for all abbreviations. This reference can be accessed via the GBMC Infoweb.
- B. Attachment A is a listing of Dangerous Abbreviations, which if used, can be misinterpreted, leading to potential errors. The use of these abbreviations in all forms of clinical documentation at GBMC is prohibited.
- C. If uncertainty exists, the person who wrote the abbreviation or symbol shall be contacted for clarification.

Date Posted on Web: 01/2011

Responsible for Review: VP of Nursing

Date Reviewed/Revised: 08/23/00, 09/03/02, 01/22/03, 05/23/03, 08/15/05,
11/03/06, 09/03/08, 01/2011

Attachment A: Dangerous Abbreviations – Do Not Use Listing

**GREATER BALTIMORE MEDICAL CENTER
DANGEROUS ABBREVIATIONS**

PROHIBITED

Abbreviation	Intended Meaning	Common Misinterpretation	Alternative
U or u	Unit	Mistaken as a zero resulting in Ten fold overdose	Unit
IU	International unit	Misread as IV (intravenous)	Units
Q.D., QD, q.d., qd and Q.O.D., QOD, q.o.d., qod	Once daily and every other day	Mistaken for each other	Daily Every other day
Trailing zero (X.0 mg) and Lack of leading zero (.X mg)		Decimal point is missed	Never write a zero by itself after a decimal point and always use a zero before a decimal point.
MgSO4 MSO4 MS	Magnesium Sulfate Morphine Sulfate	Mistaken for each other	Magnesium Sulfate Morphine Sulfate

GBMC HEALTHCARE
DEPARTMENT OF PATHOLOGY

Customer Services

For Clinical Laboratory Results (24 hours/day, 7 days/week):

To speak to a Customer Service Specialist
Phone: 443-849-2314 Fax: 443-849-6741

For Anatomic Pathology Results (7:30 a.m. – 5:00 p.m., Monday - Friday):

To speak to a Pathology Secretary
Phone: 443-849-2233 Fax: 443-849-3016

Customer Service Specialists (Clinical Laboratories) will:

- Call all outpatient critical results to the physician's office.
- Process requests for add-ons to existing orders and provide follow-up.
- Investigate and resolve problems and then provide appropriate follow-up.
- Assist with specific requirements for special laboratory tests.
- Print and ensure delivery of outpatient requisitions for private physician offices.
- Set up special research protocols.

Pathology Secretaries (Anatomic Pathology) will:

- Provide Anatomic Pathology results to physicians, if requested, by fax.
- Obtain pathology materials from outside institutions for review by GBMC. Pathologists.
- Provide patients with materials needed to obtain second opinions.

Outpatient Service Centers

Available Services

The GBMC Patient Service Center provides specimen procurement services for laboratory testing.. EKGs and Autologous and Therapeutic blood donation services are available at the Diagnostic Center .

Location on GBMC Campus

- **The Diagnostic Center** is located on the 3rd Floor just down the hall from the Main Lobby in Suite 3100. Phone: 443-849-2213

Hours of Operation

- The **Diagnostic Center** is open 6 days a week:
 - Monday – Friday: 6:00am – 7:00pm
 - Saturday: 6:00am – noon
 - Closed on Sundays and Holidays

Please Note:

- EKGs are performed Monday – Friday from 8:00am – 5:00pm.
- Appointments are required for Autologous / Therapeutic blood donors. Call 443-849-2817 to schedule an appointment at the Diagnostic Center.
- Patients are seen in the order of their arrival; however, some patients are called ahead of others due to prior scheduling or extended procedures.

Frequently Asked Questions

1. What does a patient need to bring to the Outpatient Service Center to be serviced?

The patient must bring a prescription or a completed requisition indicating:

- Lab tests to be performed
- ICD-9 codes (completed by physician's office)
- Insurance information

Note: Some patients' insurance plans do not allow them to use certain laboratories.

2. My patient needs to have blood drawn every week for the next 3 months. Is an order necessary each time the patient comes to the Outpatient Service Center?

No. This is a standing order. The original order/prescription will be kept on file in the Outpatient Service Center. A copy of the order will be made to accompany the specimen to the testing laboratory. Standing orders are kept for only 6 months. Offices utilizing eCW do not have the ability to enter standing orders.

3. My patient's lab work must be performed by Quest or LabCorp Laboratories because of insurance reasons. Can the patient be serviced at GBMC?

Yes, the patient may be drawn at the Diagnostic Center, however the Diagnostic Center provides specimen procurement services only. All Quest or LabCorp specimens will be transported to Quest or LabCorp Laboratories for testing. The ordering physician will receive test results directly from Quest or LabCorp. Patients with STAT requests for Quest or LabCorp Laboratories must be serviced at a Quest or LabCorp Laboratories Service Center. All patients that must have their lab work performed at Quest or LabCorp must present with a completed Quest or LabCorp requisition.

4. How long is the expected wait at the Patient Service Centers?

Patients are seen in the order of their arrival; however, some patients may be called ahead of others due to prior scheduling or extended procedures. During peak periods, patients may experience a longer wait. The average wait is approximately 20 minutes.

5. How do I get laboratory results on my patients?

- Inpatients: Access to the EMR is available from PCs on each of the nursing units. Lab results can be viewed.
- Outpatients: If you have access to a PC on the GBMC network, then you can access the EMR. If you do not have access to a GBMC network PC, call Customer Service (443-849-2314) and the patient's laboratory results can be relayed to you verbally or via fax.
 - Outpatient Reports are auto faxed to most physician offices
 - If utilizing eClinical Works, results will go into the medical record if matched to an order.
- **Please Note:** Laboratory results will only be provided to persons licensed under the provisions of the law. Laboratory results will not knowingly be released to patients. Patients are asked to request all laboratory results from their physician so the data can be interpreted properly.

6. How do the physician offices receive the laboratory results on their patients?

All results will be auto faxed or manually faxed. Electronic transmission to eCW is now possible if there is a corresponding order in eCW that is transmitted to Meditech.

7. What does the lab do if one of my patients has a critical value reported as a result? Or, if I need to be notified of a STAT result?

The Department of Pathology has a published list of critical values that will generate a call by the Customer Service Specialist to the physician's office (or nursing unit for the inpatients).

All designated STAT test orders, upon verification of the laboratory result, will be faxed.

- For Inpatient Units: CRITICAL results will automatically print to the designated printer in that Unit.

8. What does the lab do if the test result is not a STAT or critical value, but I still want to be notified of the result?

Requests for special handling for test results on a specific patient such as, “Call results to Dr. Smith at 828-9999” must be CLEARLY written on the laboratory requisition. A Customer Service Specialist will call the result(s) when the test is verified. **The telephone number must be listed on the laboratory requisition form (an answering service or a pager number is acceptable).** This same request can also be honored for the faxing of results.

9. How do I obtain laboratory requisition forms?

The GBMC Department of Pathology provides pre-printed laboratory requisitions to all physicians who direct their outpatients to the GBMC Patient Service Centers. To order your pre-printed requisitions, please call Customer Service Monday through Friday 7:30am – 6:00pm, or Saturdays 8:00am – 12 noon (holidays excluded).

10. How do I obtain a urine container for my patient for a 24-hour urine test?

Send the patient to the Outpatient Service Center to pick up a urine container.

For Quest and LabCorp Patients – Patients must go to one of the Quest or LabCorp Patient Service Centers.

10 Who do I call to get formalin containers?

Call the Surgical Pathology Department at 443-849-2812 to obtain formalin containers.

11. Who do I contact to discuss laboratory testing or specimen collection and processing for a research study or a clinical trial?

Contact the Customer Service Department to discuss the provisions and procedures associated with special protocols. Special accounts can also be established with the Laboratory for diagnostic testing. Please call 443-849-2091 to initiate the process.

SPECIMEN LABELLING PROCEDURE

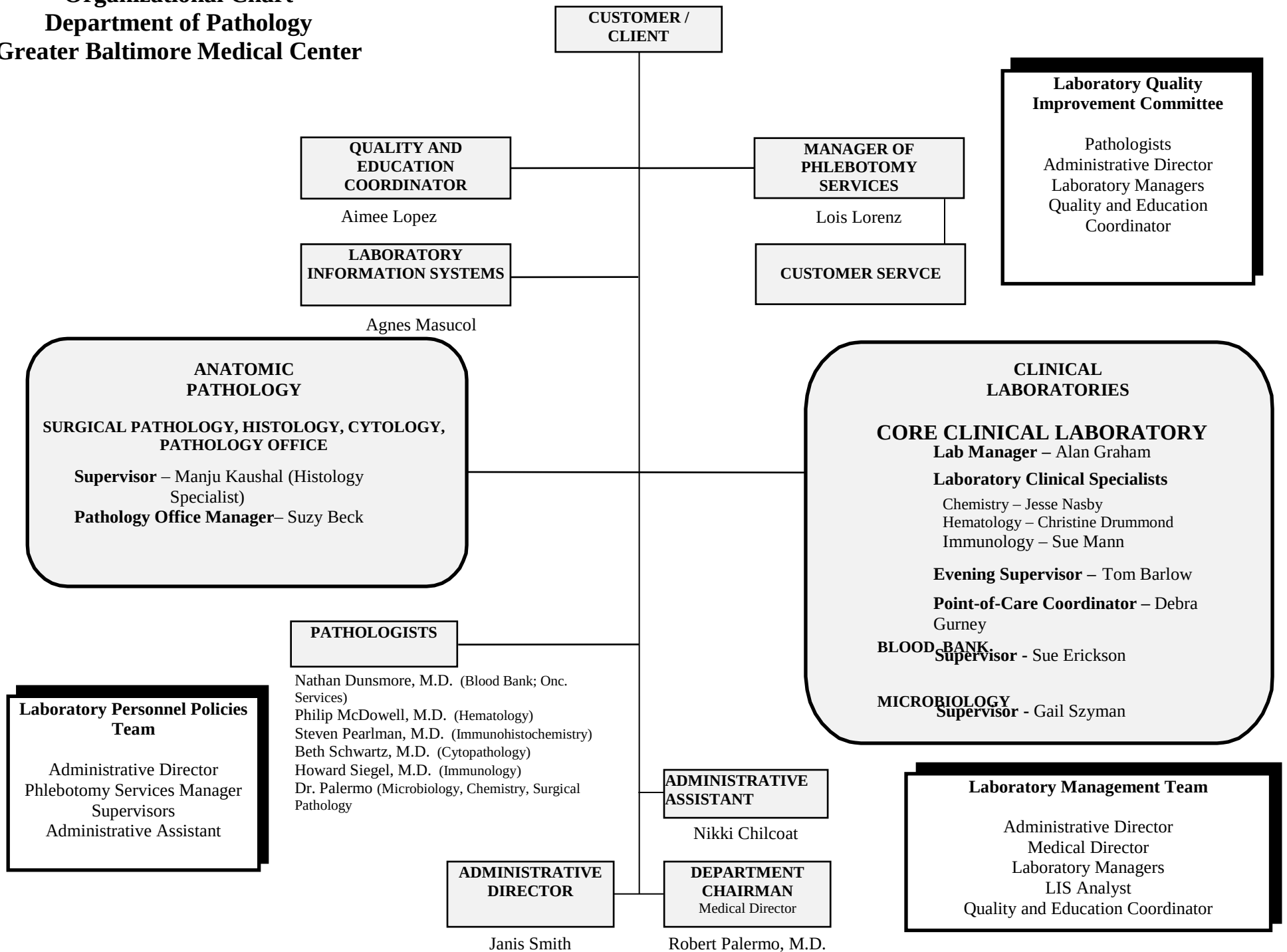
The Department of Pathology and Clinical Laboratories receives many patients' specimens for testing. Many patients have the same last name and first name (and even the same middle initial). When specimens are registered and processed within the Laboratory, they are separated from the laboratory requisitions that accompanied them. Therefore, it is imperative that all specimens submitted to the laboratory for testing are labeled with

- the patient's full name
- and the patient's social security number (or date of birth)
- date of collection, collection time and initials of person collecting specimens

To ensure that patient specimens are labeled appropriately, all specimens should be labeled in the patient's presence (either in the examining room or other drawing location). Any deviation from this procedure will put the integrity of the specimen and the safety of the patient at risk.

Please be aware this policy will be strictly enforced. Specimens will be rejected if the requested information is not present on each individual patient specimen. The physician's office will be notified per phone call of any specimen collected by the office that is not labeled properly and therefore deemed unacceptable.

Organizational Chart
Department of Pathology
Greater Baltimore Medical Center



Donor Appointment Guidelines

1. Please give patient the Donor Room Message Line 443-849-2817, as we cannot always answer the phone if we are attending other patients. Patients should leave their name, phone number, and best times to call back. We will return their call to set up donation appointment.
2. The patient has to bring a written request from their doctor, with the surgery date and the number of donations ordered. If they cannot bring it in, then the doctor's office can phone in the order and fax to our Donor Room at 443-849-3100. If the patient does not have a request, then we are not allowed to perform the procedure until one is obtained.
3. For therapeutic donations,
4. Multiple donor appointments must **not** be any less than seventy-two (72) hours apart, and the donor's surgery must **not** be less than seventy-two (72) hours from the last scheduled donation.
5. Patients should call the Donor Room as soon as their surgery is scheduled, as appointments fill quickly.
 - In case of immediate attention, such as surgical "add-on" or urgent surgery, please call 443-849-3568.

THE LABORATORY TEST DIRECTORY

The Laboratory Test Directory available to you by the following two mechanisms:

- 1). At the internet site of www.gbmc.org: On top of the screen click on Physician portal and choose the option “Laboratory Test Directory”.
- 2). On the GBMC Infoweb (intranet) site: On the top of the screen click on Clinicians. The Menu “Clinicians/Physicians Quick links” opens and then click on the “Laboratory Test Directory”.

The Laboratory Test Directory provides information related to tests available for order through the GBMC Laboratory. Information in the directory includes specimen requirements, frequency performed, turnaround time and clinical utility.

If you have difficulty locating a test, or do not see a test you would like to order, please call the Client Service Department at (443) 849-2314. If they cannot answer your question, you will be referred to the appropriate technical or medical personnel if indicated.

If you have any difficulty accessing the sites indicated above, please call the GBMC Help Desk at (443) 849-3725.

GBMC Department of Pathology and Laboratory Medicine Critical Result Notification

Title: OM05009 Critical Result Notification

Ver: 7

I. PURPOSE

To develop the most effective method of notifying the licensed caregiver of critical laboratory results. Notification of critical results of laboratory tests is medically necessary to assure appropriate care of critically ill patients. These test values represent a pathophysiological state which may be **life threatening** and require **immediate medical intervention**. **Timely communication of the results is mandatory**. The list of tests with critical values is determined by the Department of Pathology and Laboratory Medicine in conjunction with representatives of the Medical Staff and approved by the Medical Board (see Appendix A for list of tests).

II. POLICY

All critical laboratory results must be reported to the patient's licensed caregiver immediately following confirmation of the result. Standard Laboratory procedure requires that all first time critical results are confirmed by repeating the test and that a physician, nurse or other licensed caregiver must be notified by the technologist/technician performing the test or by a laboratory customer service specialist. The first attempt at notification must **occur immediately following**, but no later than 30 minutes following test verification. A licensed caregiver includes, but is not limited to the registered nurse, licensed practical nurse, advanced practitioner or physician. In the event that the patient's caregiver is not immediately available, the information may be given to the charge nurse of a unit.

III. CALL PROCEDURE

Inpatient

1. All Inpatient Critical Results will automatically print to the unit/clinic/ward that the patient is registered upon verification of results.
2. The technologist performing the test(s) will call the unit, **confirm that the patient is on that unit**, and notify the **licensed caregiver** of that patient, that there is a critical result on the patient. The technologist will indicate that the result was printed to their printer, for example, "We have a critical high glucose result on Mr. Sam Jones and it was verified and sent to print to your printer. Staff will request and document read-back of result by indicating "RBT" in the LIS documentation section. If results have not printed, they can be faxed or given verbally to the caregiver.
3. Any time a verbal report is given to a licensed caregiver read back of the test result to the technologist or customer service representative to confirm the report must be documented in LIS. If the patient has been discharged, the technologist must notify the attending physician of the critical value. If the licensed caregiver is not immediately available, the laboratorian must ask for the charge nurse and convey and document the read back in the same manner.
4. The technologist will document in the Laboratory Information System (LIS) the following information for each critical result: the name of the analyte with the critical value, the name of the person notified and whether the result was confirmed as well as the time. The caregiver will read-back the result and laboratory staff will document "RBT" for "read back test". If the patient has been discharged and the attending physician was notified, that information must be documented.
5. If results do not print to the unit, the MIS Help Desk should be called (x3725) by the unit to help resolve the printer problem.

GBMC Department of Pathology and Laboratory Medicine

Title: OM05009 Critical Result Notification

Ver: 7

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6. Redundant notification of selected critical values requires a call to the caregiver on inpatient units, and a follow up call to the patient's physician with those same results. This redundant notification to the physician may be placed by someone other than the technologist, and will also be documented. All readback requirements will apply. The algorithm for contacting the physician is documented in Appendix B. This algorithm is the basis for the logic contained in the Meditech Inpatient Physician Notification report.

REDUNDANT NOTIFICATION LIST

<u>ANALYTE</u>	<u>CRITICAL VALUE</u>
CO2	less than 15 meq/L
Magnesium, therapeutic	greater than 7.99 mg/dL
Potassium	less than 2.5 or greater than 6.0 meq/L
Sodium	less than 120 meq/L
Hematocrit	less than 20%
Hemoglobin	Less than 7 gm%
Fibrinogen	Less than 100 mg/dl
INR	Greater than 4.99
Positive blood cultures	
Positive CSF bacterial antigens	
Positive CSF gram stains (or other positive smear) or culture	

Emergency Department (ED)

1. All Emergency Department Critical Results will automatically print upon verification of results.

The technologist performing the test(s) will call the ED, and notify the physician taking care of the patient, that there is a critical result on the patient. If an ED physician is not assigned to a patient or is not available, results may be given to the charge nurse. The technologist will indicate that the result was printed to their printer, for example, "We have a critical high glucose result on Mr. Sam Jones and it was verified and sent to print to your printer. Staff will request and document read-back of result by indicating "RBT" in the LIS documentation section. If results have not printed, they can be faxed or given verbally to the caregiver.

3. Any time a verbal report is given to a licensed caregiver read back of the test result to the technologist or customer service representative to confirm the report must be documented in LIS. The technologist will document in the Laboratory Information System (LIS) the following information for each critical result: the name of the analyte with the critical value, the name of the person notified and whether the result was confirmed as well as the time. The caregiver will read-back the result and laboratory staff will document the readback.

GBMC Department of Pathology and Laboratory Medicine

Title: OM05009 Critical Result Notification

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Page 3

Outpatient

1. Calling Critical Values for outpatient results obtained during regular business hours will be the responsibility of the Customer Service Representative, who will generate a call list from LIS.
2. If after hours, the technologist performing the test will call or page the patient caregiver within 30 minutes of verification of test results. The technologist should utilize after hours emergency phone numbers provided by the office voice message.
3. In the rare event that a licensed caregiver can not be contacted, or does not return a page, after three attempts to contact him, a pathologist (on-call) will be notified by the technologist. The technologist must provide the pathologist with the following information: Patient name, patient number, birth date, physician name and number, and patient contact information, as well as the critical result and any other test result information for that patient. The pathologist on call will make the determination regarding direct patient notification. **The pathologist will read back the result and the technologist will document RBT in the LIS.**
4. Calls will be made using the phone number provided, to call the Physician's office or Health Care Provider. Critical or life-threatening results may only be communicated to the licensed caregiver at that facility. The laboratory staff member will document in the Laboratory Information System (LIS) the following information for each critical result: the name of the analyte with the critical value, the name of the person notified, the result was confirmed by read back, as well as the time. If the results are called and faxed, include that comment in the call field (ex. Critical platelet count called and faxed to Dr. Smith). All verbal, printed and faxed reports of critical values must be read back by the health care provider to verify accuracy and completeness. This must be documented as "RBT" in the LIS system comments.
5. The Laboratory must also document attempts at contacting physicians such as " Dr. Smith paged or physician office called line was busy", and indicate the date and time of those attempts.

References:

1. CAP Standards: 01:4132, 03:0660
2. CLIA Standards: 42 CFR 493.1109(f)

QM05009 Critical Result Notification Appendix A

ANALYTE		CRITICAL VALUE	REQUIRES REDUNDANT CALL TO PHYSICIAN (Inpatients Only)
CHEMISTRY			
Acetaminophen	greater than 300 mg/L		
Alcohol (Ethyl blood)	greater than 250 mg/dL		
BUN	greater than 80.0 mg/dL		
Calcium	less than 7* or greater than 12.0 mg/dL *neonate 0-3 days: less than 6		
Chloride	less than 75 or greater than 140 meq/L		
CO2	less than 15 or greater than 40 meq/L		less than 15 meq/L
Creatinine	greater than 5.0 mg/dL		
Glucose	less than 50* or greater than 450** mg/dL *neonate 0-3 days: less than 40 **neonate 0-60 days: > 200 mg/dL		
Magnesium	less than 1.0 or greater than 4.3 mg/dL		
Magnesium, therapeutic	greater than 7.99 mg/dL		greater than 7.99 mg/dL
Neonatal Bilirubin (Total)	greater than 15 mg/dL		
Potassium	less than 2.5 or greater than 6.0 meq/L		less than 2.5 or greater than 6.0 meq/L
Sodium	less than 120* or greater than 150 meq/L *infant 0 day - 1 year: less than 125 meq/L		less than 120 meq/L less than 125 meq/L

QM05009 Critical Result Notification Appendix A

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DRUG LEVELS (tests sent to reference lab reflect reference lab critical values)		
Vancomycin	Amikacin	
	Trough:	greater than 10.0 µg/mL
	Peak:	greater than 35.0 µg/mL
	Carbamazepine (Tegretol)	greater than 20.0 g/mL
	Digoxin	greater than 2.5 µg/mL
	Gentamicin	
	Trough:	greater than 2.0 µg/mL
	Peak:	greater than 10.0 µg/mL
	Lithium	greater than 1.5 mmol/L
	Phenobarbital	greater than 60.0 µg/mL
	Phenytoin (Dilantin)	greater than 30 µg/mL
	Salicylate	greater than 400 mg/L
	Theophylline	greater than 25.0 µg/mL
	Tobramycin	
	Trough:	greater than 2 mg/L
	Peak:	greater than 10.1 mg/L
	Valproic Acid	greater than 125 mg/L
	Vancomycin	
	Trough:	greater than 22.0 ug/ml
	Peak:	greater than 40 µg/mL

QM05009 Critical Result Notification Appendix A

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HEMATOLOGY		
Blast Cells	1 or greater	
Hematocrit	Less than 20 % or greater than 60.0%* *neonate 0-7 days: greater than 65%	Less than 20%
Hemoglobin	Less than 7 or greater than 20.0 gm%	Less than 7 gm%
Malarial Parasites	1 or greater	
Platelets	Less than 50,000 or greater than 999,000	
Positive APT test		
WBC	Less than 2,000* or greater than 30,000** *neonate 0-30 days: less than 5,000 **neonate 0-30 days: greater than 30,000	
COAGULATION		
APTT	greater 119.9 sec.	-
Fibrin Split Products	Greater than 80 mcg/dl	
Fibrinogen	Less than 100 mg/dl	Less than 100 mg/dl

GBMC PAT and Posting Departments Guidelines and Information Reference

January 2013

GBMC

Section I – Posting

About Surgical Posting Department

Department Hours

- Surgical Posting Department **answers calls from 7:30 a.m. to 5:00 p.m.** Monday through Friday
- You may leave a voice mail message before or after our normal hours of operation. We **endeavor to return ALL calls within 24 hours** of receipt
- Your case is **not officially posted until you receive confirmation** from the Posting Office

Who to Call for Scheduling Add-on and Emergent/Urgent Cases

- Posting Department takes call during normal hours of operation (as above) for elective case posting **AS WELL AS** calls up to 2:00 p.m. for add-on cases for the following day
- The General Operating Room (GOR) Control Desk takes calls to post **SAME DAY** emergent/urgent cases **AND** takes calls after 2:00 p.m. for add-on cases for the following day

Staff Contacts

- Roberta Cordara, RN, RNFA, Posting Manager, telephone 443-849-3442
- Names of staff members:

Suzie Whitaker	Tracie Brown	Tracy Joyner
	Darlene Johnson	Deborah Cox

- Main Telephone # 443-849-6700

MAIN TELEPHONE # 443-849-6700

PHONE CHANGES

ONCE THE MESSAGE COMES ON YOU CAN IMMEDIATELY PRESS THE NUMBER FOR YOUR SERVICE.

IF SCHEDULER IS ON ANOTHER LINE, YOU WILL BE DIRECTED TO HER VOICEMAIL AND YOU WILL RECEIVE A CALL BACK.

PHONE OPTIONS:

PRESS 1 – CHANGES TO NEXT DAY SCHEDULE

PRESS 3 – BARIATRICS, GYN – DARLENE JOHNSON

FAX #443-849-3911

PRESS 4 – SUZIE WHITAKER – ENT, HEAD & NECK, ORAL SURGERY & PEDIATRIC GENERAL SURGERY

FAX # 443-849-3916

PRESS 5 – TRACY JOYNER – ORTHO, NEURO & PAIN, GENERAL SURGEY

FAX # 443-849-3915

PRESS 7 – DEBBIE COX – EYES, PLASTICS & PODIATRY

FAX # 443-849-3913

PRESS 8 – TRACIE BROWN – VASCULAR, PULMONARY & DAVINCI

FAX # 443-849-3914

THE SCHEDULERS WILL NO LONGER ANSWER PHONE CALLS ON ANY LINE OTHER THAN THE ABOVE OPTIONS.

WHEN A SCHEDULER IS OFF OR ON VACATION HER PHONE WILL BE FORWARDED TO AN ASSIGNED ALTERNATE.

How to Post a Surgical Case?

- **Surgeons with Block Time** at GBMC may **post cases via fax or online** (<http://www.gbmc.org/surgicalposting>)
- **Surgeons without Block Time** may **post cases via telephone**
- The **minimum information required to post a case** that must be available at time of posting **includes**:
 - **Date/Time Requested, Surgeon, Site, Procedure, Patient Type** (Inpatient, Outpatient, AM Admit, 23-hour Observation)
 - **Patient's Name (Last, First and Middle Initial)**, (Parent's name if patient is a minor), **DOB, Social Security #, Address, Home/Business/ Cell Phone Numbers, Weight/BMI**
 - **Patient's Insurance Carrier, Policy Number/Group Number, Subscriber's Name and DOB**
 - **Diagnosis, Post-operative disposition** (SICU, SIMCA)
 - Request for **Assisting Doctor/Contract Surgeon, RNFA or 2nd Scrub, Resident, Colon/Rectal Fellow, Specific Equipment Needs/Vendors, Need for Blood, Type of Anesthesia**
 - **Implants and/or Supply Equipment Specialty Requests** should be communicated
 - Indicate if **Clinical Trial**
 - **LATEX Allergy**
 - **Sleep Apnea, pacemaker/AICDs**
 - **Place of Pre-Surgical Testing** and **Primary Care Physician** contact information
- Cases should be **posted by the Procedure Name** as listed on the Surgeon-specific List of Procedures previously provided
 - Each procedure on the list has a specific Preference List in our computer system that gives us the Surgeon's preferences/needs for supplies, equipment and room set-up for that particular case
- The time for the case will be **posted according to the average procedure time** in our computer system which updates the surgeon's historical case time experience during the past month
- **Scheduled Turnover varies by Location, Service, Procedure**
- A **FAX confirmation will be automatically returned for ALL cases** that have been posted in our computer system

GBMC ON-LINE SURGICAL POSTING

www.gbmc.org/surgicalposting

Complete the on line form and submit.

If your block time has released, you must call to be sure time is available before sending your on line posting request.

Please call Surgical Posting at 443-849-6700, for all cases within 24 hours that need to be canceled or rescheduled.

All fields that have an asterisk (*) are required.

If required fields are not filled, the form will **not** submit.

You will be prompted to fill in required fields.

When the posting form is complete it will submit to the Scheduling Office.

A confirmation that we have received posting will be e-mailed back.

A confirmation will be sent via fax when the case is posted.

The turn around time for all e-mail postings is 48 hours.

Thank You,
Roberta Cordara
Nurse Manager, Posting/
Pre-Surgical Testing
443-849-3442
rcordara@gbmc.org

GBMC Surgical Posting - Windows Internet Explorer

http://www.gbmc.org/body.cfm?id=1337&fr=true

File Edit View Favorites Tools Help

GBMC Surgical Posting

Print This Page | Email to a Friend | Adjust Font Size

Welcome to GBMC Surgical Posting

For all scheduling beyond 72 hours:

To reschedule or cancel an already scheduled case:

If the posting is for within 72 hours please call the Schedule Department at 443-849-6700

GYN / Bariatrics	Click Here	Click Here
Podiatry / Plastics / Cosmetics / Ophthalmology	Click Here	Click Here
Vascular / Thoracic / Pulmonary / Urology / DaVinci	Click Here	Click Here
Ortho / Neuro / Pain / General Surgery	Click Here	Click Here
ENT / ENT Oncology / Oral Surgery / Pediatric General Surgery	Click Here	Click Here

- Video Library
- Anesthesiology
- Breast Care
- Colorectal
- General Surgery
- Hyperbaric Medicine/HBO Unit
- Minimally Invasive
- Neurosurgery
- Ophthalmology
- Otolaryngology/ENT
- Orthopedic
- Pediatric
- Plastic
- Podiatry
- Robotic Surgery
- Thoracic
- Urology
- Sherwood Surgical Center
- Vascular
- Weight Loss
- Wound Care

Block Time Policy Overview

- For maximum efficiency OR time is organized in blocks and is allocated to physicians, groups, and services on the basis of need as indicated by utilization in the past quarter.
- **New Requests for Block Time will be submitted in writing** to the Surgical Scheduling Manager, who will present to the Peri-Operative Executive Committee.
 - Requests will be **reviewed and allocated by the Peri-Operative Executive Committee.**
 - **The surgeon has a probationary period of three months to achieve 70% utilization.**
 - Physicians requesting **ADDITIONAL Block Time must demonstrate a utilization of current block time of at least 70% with consistent additional hours of surgery outside of block for a consecutive 3 month period.**
 - **A minimum of 70% utilization per month is required to maintain block time.**
 - **Block Time Utilization is reported quarterly.**
 - **Block Time is defined as the average utilization for a 3 month period and will be reviewed by the Peri-Operative Executive Committee. Utilization will be used to maintain allocated block as well as released time of allocated block.**
 - In the event that a physician is on vacation or otherwise not using their block time they may voluntarily release established blocks or any portion of the bloc if they are unable to use the time. Voluntary block time releases should be faxed to Surgical Posting at 443-849-3744 three weeks in advance of the day in question.
- This Overview DOES NOT include all aspects of our Block Time Policy. For a copy of the Policy, please contact the Surgical Scheduling Manager at 443-849-3442.

GBMC URGENT/EMERGENT CASE CLASSIFICATION

APRIL 2011

A (≤ 30 minutes)	B (< 2 hours)	C (< 6 hours)	D (within 24 hours)
• Airway compromise/acute hematoma postop head & neck surgery or any other reason (thyroid, carotid, etc) • foreign body airway or esophagus with respiratory compromise • exsanguinating hemorrhage any location or reason (head & neck, thorax, abdomen, extremity) • expanding hematoma (chest, abdomen, neck, ext) • pericardial tamponade • ruptured ectopic pregnancy, unstable • ruptured thoracic/abdominal aneurysm • acute intracranial bleeding • imminent brainstem herniation • renal trauma • pneumoperitoneum in newborn • pediatric volvulus (newborn)	• GI bleeding with hypotension • perforated viscus with hypotension/systemic sepsis • large or small bowel obstruction with hypotension/systemic sepsis • acute abdomen or peritonitis in unstable patient, any service or reason • necrotizing soft tissue infection, any location • endo-ophthalmitis • globe foreign body/laceration • acute spinal cord compression with neurologic compromise • free flap w/ potential compromise • stable non-ruptured ectopic pregnancy • adnexal torsion • re-exploration for postoperative bleeding (any service) • limb/bowel threatening arterial ischemia • symptomatic pseudoaneurysm • crescendo TIAs • compartment syndrome, upper or lower extremity • postoperative tonsillar bleeding • re-exploration free tissue transfer for suspected vascular compromise • urinary bladder perforation • acute dot or urinary retention after urologic surgery • priapism • ruptured testicle • pediatric incarcerated hernia • pediatric wound dehiscence with evisceration • pediatric pneumoperitoneum • pediatric bowel obstruction	• stable or chronic GI bleeding • small bowel obstruction (SBO) w/ suspected strangulation, including acute incarcerated hernias • esophageal foreign body, acute • uncomplicated large bowel obstruction • appendicitis w/ perforation or sepsis • acute biliary sepsis with or without obstruction (cholangitis or unstable acute cholecystitis) • abscess drainage (any location) or wound debridement w/ sepsis • stable intestinal ischemia • glaucoma emergency • retinal detachment, urgent • open fracture, any location • major joint dislocation • acute septic joint (excluding total joint replacement) • infected prosthetic implant, any type • esophageal leak or perforation • mediastinitis • uncontrolled bronchopleural fistula • vulvar abscess with sepsis • infected pelvic mass, tubo-ovarian abscess • deep space vascular infection • acute peripheral nerve compression • urinary obstruction w/ sepsis • penile fracture • paraphimosis • patent ductus arteriosus (PDA), premature infant	• SBO, uncomplicated • appendicitis, uncomplicated • acute cholecystitis, uncomplicated • abscess drainage (any location) or wound debridement, uncomplicated • endoscopic treatment postoperative stricture • inguinal hernia, symptomatic • retinal detachment, non-emergent • ORIF hip, ankle, long bone fracture • wound dehiscence, stable • thoracic empyema • malignant pleural effusion • lung biopsy • ruptured bleb, persistent air leak • vascular graft infection • arterial ischemia, non-limb threatening • acute mastoiditis • acute sinusitis with abscess • urinary tract stones, uncomplicated • pediatric vascular access • pediatric pyloromyotomy

Section II – Pre-Surgical Testing

Pre-Surgical Testing Department

Our goal is to ensure safe and efficient surgical care by partnering with you to have all required pre-surgical testing requirements before the day of surgery.

Department Hours

- Pre-Surgical Testing Department answers calls from 7:30 a.m. to 4:30 p.m. Monday through Friday
- You may leave a voice mail message before or after our normal hours of operation. We endeavor to return ALL calls within 24 hours of receipt (except for calls received on the weekends)
- Patients can be scheduled for Pre-Surgical Testing appointments with our Nurse Practitioner from 8:00 a.m. to 3:00 p.m. Monday through Friday

How to Make an Appointment for your Patient

- All Pre-Surgical appointments are scheduled during the Posting of a case and may be cancelled or changed by calling the Posting Department @ 443-894-6700
- If your Patient is having Pre-Surgical Testing done by his/her Primary Care Physician, please provide that information upon posting the case

Staff Contacts

- Roberta Cordara, RN, RNFA, Pre-Surgical Testing Manager; telephone 443-849-3442
- Names of staff members:

Sharon Short, RN	Nancy Rizer, RN		Beverly Bye, NP
Tina Herzing	Chametra Chase	Renee Tankersley	Bernadine Wilson

- Main Telephone # 443-849-3196 general inquiries and 443-849-3420 to contact Registered Nurse
- Fax #: 443-449-8000 – Any information about cases scheduled in Women's Surgical Center
- Fax # 443-849-2700 – Any information about either Joint/Spine Cases OR Ophthalmology cases
- Fax #443-849-3013 – Any information about cases in General Operating Room
- Fax #443-849-8182 – Any information about cases in Sherwood Surgical Center

What is Required to Clear Patients BEFORE Day Of Surgery?

Requirement	When and Why
Anesthesia Pre-Surgical Testing Guidelines Form	• Upon posting of case or not later than 48 hours in advance of DOS to establish "requirements for clearance" • PAT RNs complete chart clearance by noon day before DOS • Case may have to be cancelled or delayed if all requirements for clearance have not been obtained and/or unknown medical conditions are discovered less than 48 hours prior to DOS in order to ensure the safety of patient
H&P	• ALL PAPERS MUST HAVE D.O.B. & NAME ON IT FOR IDENTIFIERS & PATIENT SAFETY • Upon posting of case or not later than 48 hours in advance of DOS; in accordance with Medical Staff bylaws • 96 Hours Prior to DOS; PAT will contact Surgeon's office for H&P or health status of patient • If not received PRIOR to DOS by PAT staff; Surgeon should plan to arrive 30 minutes prior to scheduled case start time to complete H&P
Informed Consent	• Receive by noon day before DOS • Surgeon is requested to arrive 20 minutes prior to scheduled start time if an Informed Consent needs to be executed
Cardiac Clearance and Other Consults	• Cardiac Clearance or other consults should be submitted at least 48 hours in advance of DOS, as additional tests/work-up may be required prior to surgery • If patient is scheduled as First Case; surgery MAY have to be delayed and/or cancelled at discretion of Anesthesia Manager (as informed by Pre-Op and OR Charge RN) in order to ensure the safety of your patient • To follow cases may also be postponed to the end of the schedule, if it is anticipated that required clearances will not be obtained within four hours prior to scheduled time
Results: Labs, EKG, CXR	• Test Results should be submitted upon receipt at the Surgeon's office, but at least 48 hours in advance • Stat labs can be accommodated on an as-needed basis for emergent cases or DOS redraws , BUT should not be standard protocol for clearing patients

All Documents must be COMPLETE and LEGIBLE

GBMC HEALTHCARE INC.
PERIOPERATIVE SURGICAL SERVICES

Pre-Surgical Testing

Phone: GOR 443-849-6445 Fax: 443-849-3013

SSC 443-849-6325 Fax: 443-849-8182

WSC 443-849-3239 Fax: 443-849-8000

Spine/Total Joints/Eye 443-849-3196 Fax: 443-849-2700

History & Physical- within 30 days

EKG- within 30days

Labs-within 30 days

CXR/CT- within 6 months

PRE-SURGICAL TESTING GUIDELINES:

1. Every anesthesia patient must have a **HISTORY AND PHYSICAL** no more than 30 days old. Update done by surgeon DOS on purple H&P form.
2. All **TEST RESULTS MUST** be faxed to GBMC within 72 hours of patient's surgery.
3. **NAMES, DATE OF BIRTH AND DATE TEST PERFORMED** must be on all tests and pages.
4. All **LAB WORK** must be done within 30 days. **Pregnancy tests are valid for 7days: otherwise a urine test will be performed at the hospital the day of surgery.**
5. **EKG'S** No more than 30 days old. Interpretation and Physician signature is needed on EKG.
6. **CHEST X-RAY OR CT'S** no more than 6 months old. **CXR'S** not required for Eye surgery.
7. **CARDIAC CLEARANCE:** Any patient with a documented history of cardiac disease (CAD with or without h/o MI, any patient s/p CABG or stents, h/o CHF, arrhythmias, significant valvular disease etc.) **should have their cardiac issues specifically addressed.** In addition, any patient with a new finding of an abnormal EKG (ischemic changes, abnormal rhythm) should be evaluated preoperatively. **The physician preparing the pre-surgical evaluation must specifically comment on each cardiac issue or refer to a cardiologist to do so. Any patient with unstable cardiac status must have a consultation by a cardiologist.**
8. Patients with a past medical history of a CVA within 6 weeks of surgery need pre-op medical clearance.
9. **The pre-surgical evaluation of any patient on anti-coagulation medicines (e.g. Coumadin) must specifically address the issue of whether bridging with other anti-coagulation medicines is required and if so, what regimen should be utilized.**

GUIDELINES FOR MEDICATION:

Consult with your Primary Care Doctor as to **instructions for taking insulin** on the day of surgery.

Patients taking Aspirin, Aspirin products, Plavix, Coumadin, Warfarin should consult their physician or cardiologist in regard to taking medicine day of surgery.

Patients taking antidepressant, antianxiety, and psychiatric medications should continue day of surgery. Please consult prescribing physician if any concerns.

Vitamins, Iron, Premarin discontinue day of surgery.

Topical medications (creams and ointments) should be discontinued day of surgery.

Metformin, Glucophage, Glucovance, Avandamet, and Actos-Plus **MUST be stopped 24 hours prior to surgery.**

Viagra, Levitra, Cialis or similar drugs should be discontinued 36 hours prior to surgery.

All anti-inflammatory medications (e.g. Ibuprofen, Advil, Motrin, Naproxen, etc) **MUST be stopped 48 hours prior to plastic or retinal surgery.**

All herbal medications and non-vitamin supplements **MUST be stopped SEVEN days prior to your surgery.**

Diet medications **MUST be stopped SEVEN days** prior to surgery.

Birth control pills continue day of surgery.

Eye drops continue day of surgery.

Narcotic pain medications continue day of surgery.

Antiseizure medications continue day of surgery.

Steroids (oral and inhaled) continue day of surgery.

Statins (Zocor, Lipitor) continue day of surgery.

Cardiac medications (Digoxin) continue on day of surgery.

Blood pressure medication and diuretics, continue on morning of surgery

COX-2 inhibitors (Celebrex, Vioxx) continue day of surgery.

Thyroid medication continue day of surgery.

Heartburn or reflux medication such as acid blockers (Zantac, Pepcid, Axid, Prilosec, Propulsid, Reglan) **SHOULD be taken** on the **morning of surgery** to reduce the risk of pneumonia. However, antacids such as Maalox, Tums or Carafate **SHOULD NOT** be taken because they contain particulate material that may damage the lungs if aspirated.

MINIMAL PREOPERATIVE REQUIREMENTS BY AGE:

PEDIATRIC 0-6 MONTHS:

H & P / HCT

PEDIATRIC 6 MTHS-18 YRS:

History and Physical Only. (Exception: tonsillectomy requires HCT, menstruating females need HCT & HCG).

ADULT MALES <40:

History and Physical ONLY

*** see exceptions**

ADULT MALES 40-69:

H & P, HCT, EKG

***see exceptions**

ADULT MALES 70 and over:

H & P, HCT, EKG, CXR, Glucose, BUN, Creatinine

*** see exceptions**

ADULT FEMALES <50:

H & P, HCT & HCG

*** see exceptions**

ADULT FEMALES 50-69:

H & P, HCT & EKG

*** see exceptions**

ADULT FEMALES 70 and over:

H & P, HCT, EKG, CXR, Glucose, BUN, Creatinine

*** see exceptions**

***EXCEPTIONS:**

PREOPERATIVE CONDITIONS:

Cardiovascular disease (HTN, MI)

HCT, Lytes, EKG

Angina, arrhythmia: also need G/B/C

Atrial Fib and CHF: also needs CRX, PT/PTT

Aortic Stenosis: also needs recent Echo

Pulmonary disease (Severe asthma, SOB, >20 pk yr smoker):

HCT & CXR

COPD, EMPHYSEMA

also needs EKG, G/B/C

Renal disease (peritoneal & hemodialysis need K & Na within 24 hours of surgery):

HCT, Electrolytes, Glucose, BUN, Creatinine, EKG, CXR

Hepatobiliary disease (Exposure to hepatitis, drug abuse, excessive alcohol use, biliary disease):

HCT, Platelets, PT/PTT, Electrolytes, Glucose, BUN, Creatinine, Liver group

Diabetes:

HCT, Electrolytes, Glucose, BUN, Creatinine, EKG

Malignancy(Radiation or Chemotherapy within 3 months):

CBC, Lytes, Glucose, BUN, Creatinine, CXR or CT of the chest

Infection:

CBC

HIV:

also needs CRX, G/B/C

Anticoagulant use or bleeding disorder:

HCT, PT/PTT, Platelets

Endocrine disease or morbid obesity (BMI greater than 45 or Weight > 300lbs):

HCT, Electrolytes, Glucose, BUN, Creatinine, EKG

Diuretic use:

HCT, Electrolytes

PROCEDURE:

Laparoscopic (procedures of the abdomen, chest and pelvic region):

HCT, T&S IF Hct <28

Major Neurosurgical/Thoracic/Splenic/Major abdominal/Major Vascular/Urologic:

EKG, CXR, CBC, Platelets, PT/PTT, Lytes, G/B/C, LFTs, T&S Also UA for Urology cases.

Myomectomies/TAH:

CBC, Lytes, T&S

GYN Resectoscope:

HCT, Lytes

Urologic Resectoscopes (TURB/TURP)

HCT, Lytes, T&S

Total Joint Replacement:

EKG, CXR, CBC, PT/PTT, Electrolytes, Glucose, BUN, Creatinine, T&S,
Clean caught UA (if Abnormal do C+S).

Spine Cases with Instrumentation/fusion:

CBC, PT/PTT, Lytes, G/B/C, EKG, T&S

D&C for incomplete, missed or therapeutic abortion:

HCT and Rh screen required

Revised 6/01/2009

Reviewed 1/2012

OUTPATIENT HOME MEDICATION RECONCILIATION FORM

Date: _____ Time: _____

MEDICATION / HERBAL / VITAMINS / CONTRAST / OVER THE COUNTER

Allergy or Adverse Reactions	TYPE	SEVERITY	DATE

Changes/ New Orders

[illegible]

What is Required in a Complete History & Physical?

[illegible]

Minimal Requirements:

- Documentation of recent and past medical history;
 - Indication for surgery/procedure;
 - Current medications;
 - Known Allergies;
 - Vital signs; and
 - Physical Exam appropriate to patient's condition
- Legible Signature of Practitioner performing H&P exam
AND SURGEON

WHEN

Complete H&P exam must be WRITTEN no more than 30 days before surgical procedure for ALL patients that will receive Anesthesia during surgery

Update note MUST be done regardless of any change in patient's status for All H&Ps

WHO

Surgeon may delegate responsibility for H&P exam to other practitioner, BUT surgeon MUST SIGN for and ASSUME full responsibility for these activities

REVIEW OF SYSTEMS						
EYES:	Blurred vision, double vision, cataracts, glaucoma					
EKT:	Strabismus, strabismus, hearing loss, otitis media, frequent sore throats, hoarseness					
CHS:	Recurrent, dizziness, syncope, weakness, numbness, headaches					
ENDOCRINE:	Thyroid Disease, recent weight change, breast, DM					
BREASTS:	Lumps, pain, discharge					
CARDIOVASCULAR:	Chest pain, palpitations, edema, claudication, phlebitis					
PULMONARY:	SGB, hemoptysis, productive cough, wheezing, asthma, pneumonia					
GI:	Recent change in bowel habits, ulcer, HT, GB disease, colitis, hemorrhoids, dysphagia, abdominal pain, jaundice, blood in stools, melena					
GU:	Frequent UTIs, renal stones, dysuria, hematuria, frequency, nocturia					
PHYSICAL EXAM						
TCID:	BLOOD PRESSURE	TEMP	HEART RATE	TEMPERATURE	HEIGHT	WEIGHT
Integument: Skin, hair, nails						
Head/Neck: Skull, thyroid, carotids						
Eyes: Pupils, conj., sclera						
ENT: Canals, TM's, mucosa						
Lymph Nodes: Cervical, supraclavicular, axillary, ing						
Breasts: Symmetry, palpation, nipples						
Lungs: Respirations, percussion, breath sounds						
Heart: PMI, rhythm, ecg, murmurs						
Peripheral Vascular: Femoral, dorsalis pedis, distal						
Abdomen: Tenderness, masses, scars, inspection						
Extremities: Edema, varicoseles, color						
Neuro: Motor, sensory, orientation						
Other Pertinent Findings:						
Impression:						

SAMPLE

Form 202-288 (1/5/01)
MD
DATE

GBMC
6701 North Charles Street
Baltimore, Maryland 21204

**CONSENT TO DIAGNOSTIC, OPERATIVE,
THERAPEUTIC, BLOOD TRANSFUSION AND
PHARMACOLOGICAL PROCEDURE**

Date of Procedure: _____ AM
PM

Name of Patient: _____ (type or print.)

1. I consent to the performance of the following procedures upon the Patient, under the direction of Dr. _____, as the physician in charge; these procedures may be performed by him/her or anyone whom he/she may designate:
 - (a) Physical examinations, other routine diagnostic procedures and routine medical treatment;
 - (b) The following operative, special diagnostic or therapeutic procedures:

 - (c) The injection or other administration of the drugs or other substances incidental to any procedure described in subparagraph (a) above.
 - (d) Any other procedure related or incidental to those enumerated above, if within a reasonable degree of medical certainty the procedure is necessary to avoid a substantial risk of death or immediate and serious harm to my health, and someone authorized to give consent on my behalf is not reasonably available to make the decision.
 - (e) At the option of my surgeon, the videotaping or photographing of any surgical procedure for diagnostic purposes or for educational or research use under circumstances in which my identity will be protected from disclosure to persons not otherwise involved in my care.

NOTE: THIS IS A TWO SIDED FORM

2. I consent to the study, use and disposal by Medical Center authorities of any tissue or parts that may be removed.
3. I consent to the administration of blood and blood products, if required, by any person qualified to do so. I understand that blood or blood products may be needed to correct anemia, replace blood lost during a procedure or to help my blood clotting. Uncommon reactions may include chills, fever or a rash. Rare but more serious conditions may be heart, kidney or other organ failure, a reaction due to blood incompatibility or acquiring an infectious disease such as Hepatitis or HIV (AIDS.) These procedures, possible alternatives such as autologous donations, and their respective risks and benefits have been explained to my satisfaction.
4. No warranty or guarantee has been given to me by anyone as to (a) the results that may be obtained from the procedures covered by Paragraph 1, or (b) the fitness or quality of any drug, anesthetic, blood or blood product or other substance to be used in those procedures.
5. I understand there are risks involved in all procedures. These include but are not limited to infection, hematoma, hemorrhage, pneumonia, heart attack, stroke, urinary tract infections, nerve damage and even death. Other specific risks include:

6. These procedures, possible alternative procedures, and their respective risks and benefits have been explained to my satisfaction by the physician in charge

DO NOT SIGN THIS FORM UNLESS YOU HAVE READ IT, UNDERSTAND IT, AND AGREE WITH WHAT IT SAYS.

Witness Signature

(Print Name)

(Patient Signature)

(Print Name)

(Other Authorized or Required to Consent)

(Relationship to Patient)

NOTE: THIS IS A TWO SIDED FORM

Section III – Important Contacts

Important Contact Information at GBMC

Reason To Call	Name	Contact Information
• Questions regarding patients' health status, Anesthesia Plan of Care for patients on TODAY'S schedule	ANESTHESIOLOGIST ON CALL	Telephone: 443-849-3586
• Resolve Issues or Policy Questions related to Posting and/or Pre-surgical Testing	Roberta Cordara, RN NURSE MANAGER	Telephone: 443-849-3442 Rcordara@gbmc.org
• Emergent/Urgent Case Scheduling • Surgeon Delayed • Inquire about status of OR time for Surgeon with Scheduled Case	Control Desk @ General Operating Room Clinical Partner @ General Operating Room	Telephone: 443-849-2240 Telephone 443-849 3588
• Surgeon Delayed in Getting to Scheduled Case • Inquire about status of OR time for Surgeon with Scheduled Case	Clinical Partner @ Sherwood Surgical Center Holding Area (Pre-Op)	Telephone: 443-849-8440 Telephone: 443-849-2416
• Surgeon Delayed in Getting to Scheduled Case • Inquire about status of OR time for Surgeon with Scheduled Case	Clinical Partner @ Women's Surgical Center Holding Area (Pre-Op)	Telephone: 443-849-6807 Telephone: 443-849-8041
• Provide information/inquire about any pre-surgical testing requirements, patient-specific pre-surgical test results and/or clearances, status of patient clearance for surgical procedure	Sharon Short, RN @ Pre-Surgical Testing Nancy Rizer, RN @ Pre-Surgical Testing	Telephone: 443-849-3420 Sshort@gbmc.org Nrizer@gbmc.org
• Post, Change or Cancel Case	Posting Department	Telephone: 443-849-6700

Additional Brochures

For Additional Copies of Brochures, please contact:

Brochure Type	Department/Contact Person	Phone Number
Visitor Guide	Marketing	443-849-3219
Patient Rights	Roberta Cordara	443-849-2015
Notice of Privacy Practices	Roberta Cordara	443-849-3442

Quality and Patient Safety

Carolyn L. Candiello
VP, Quality and Patient Safety

443-849-3412 ccandiello@gbmc.org

Accreditation and Regulatory Committee (ARC)

- Includes Vice-President of Quality and Safety, Sr Vice President Patient Care Services & Chief Nursing Officer and Chapter Leaders.
- Review of mock tracers, TJC *Perspectives* and *OnLine*.
- PPR-MOS Data Presentation
- Regulatory Updates
- Joint Commission Outpatient Sub-Committee Report



Accreditation and Regulatory Committee (ARC) Outpatient Setting Focus Group

- Statement of Purpose: To provide safe and effective care of the highest quality in GBMC Outpatient Settings in compliance with Joint Commission Standards.
- Topics: Compliance and protocols for the Ambulatory Summary Sheet Process/Forms, Falls Policy, and Pain Assessment, Pediatric Crash Carts in Outpatient Settings, Medication Management, and Suicide Risk Protocol.



Lymphedema



Ophthalmology



Otolaryngology

Improve Accuracy of Patient Identification

- Use **TWO** patient identifiers- **NAME AND DOB**- when administering medications, collecting blood samples and other specimens for clinical testing; **when giving blood, doing procedures, treatments, transporting, or providing meals!!**
- The patient's room number or physical location is *not* used as an identifier.
- Must use "active communication" Please TELL ME your NAME and DOB.

Policy: Patient Identification



Universal Protocol



- Make sure that the **correct surgery** is done on the **correct patient** and at the **correct place** on the patient's body.
- **Mark the correct place** on the patient's body where the surgery is to be done.
- **EVERYONE Pauses** before the surgery to make sure that a mistake is not being made.
- **Document the Time Out**

Policy: Universal Protocol

Improve Communication

- Purpose: To communicate critical results to the licensed caregiver so that action may be taken to prevent avoidable delays in treatment or response. GBMC will be proactive in its approach to communicating critical results throughout the organization

•Person receiving the call from the lab regarding a critical laboratory result is to call the licensed caregiver within 60 minutes and document this call.

•The licensed caregiver is to read back the result to the caller.



Policy: CRITICAL VALUES REPORTING



FALL REDUCTION AND HAND OFFS



At GBMC we

- Assess patients for risk for fall and implement strategies as appropriate
 - Patients at HIGH RISK - **Red Blanket** and nonskid **Red Socks** and utilizing other nursing interventions.
 - Patients at MODERATE RISK – **Orange Blanket, Orange Socks**
 - Patients also have **color coded wrist bands** in addition to socks & blanket.
 - Educate patients and families about fall risks.
 - Reduce fall risk hazards – clutter, supplies, wet floors
 - Re-assess patients for fall risk **twice** daily.
 - Communicate fall risk to other caregivers at “Hand Off”
 - **HAND OFF** – standardized approach to “hand-off” communications, including an opportunity to ask and respond to questions.
 - **Whenever there is a change in caregivers there needs to be hand-off. Include up to date information regarding the patient's condition, care, treatment, medications, services and any recent or anticipated changes.**
- 

Policy: FALL RISK ASSESSMENT, PREVENTION AND MANAGEMENT, ADULT

Interpreter Services

Effective Communication is an essential component of patient quality care and safety.

Every patient has the right to receive communication in a manner they understand. GBMC now provides interpretation services through Cyracom.

- If you are in need of an interpreter, please use the blue, dual handset CryaCom ClearLink telephone available on all patient care units.
- To view the training videos go to the InfoWeb: Home → Department → Interpreters



ROADMAP TO GETTING INTO ACTION



QUANTROS **What to report?**

**Anything that happens, that shouldn't
happen involving the care of patients**

**Or any incidents involving injury or harm
to visitors**

Examples of what to report

- Falls
- Pressure Ulcers
- Medication Errors
- Complications
- Delays in care
- Any injury to a patient
- Medical equipment failure
- Visitor falls

QUANTROS

Why Reporting is so important?

- To continue to **learn** and improve
- To **prevent** it from happening again
- To **recognize** “good catches”
- Most importantly, it’s the **right thing** to do



Who should complete an incident report?

- If you were **involved** in an incident
- If you were **informed** of an incident
- If you **discovered** the incident

NOTE: It is OKAY if more than one person submits an incident report on the same issue



When should I report?

- As soon as it is reasonably possible (after you have taken care of any patient issues)
- ALWAYS before your shift is over

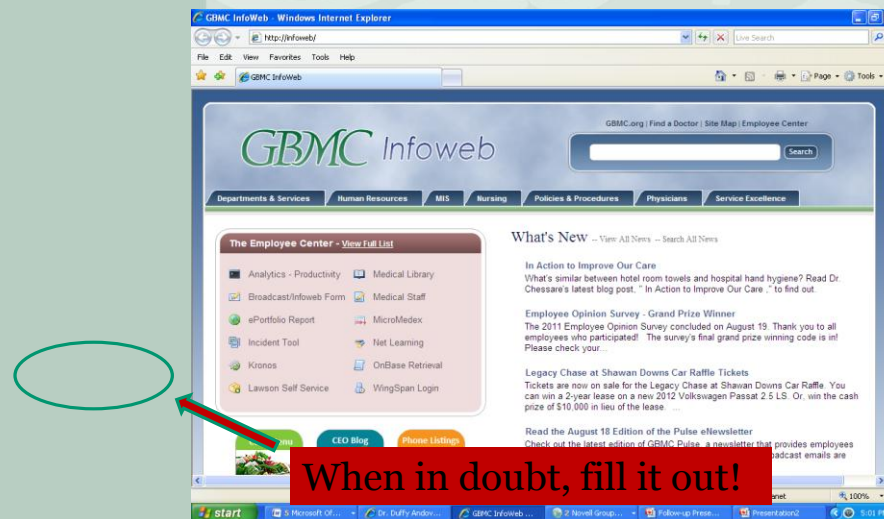


What Happens After I report?

- Quality and Safety Department receives each incident
- The incident is reviewed by the department the incident occurred
- Opportunities to improve are identified and shared



Where to report - Infoweb



Quantros = User Friendly

The screenshot shows the 'Patient and Safety Event Manager' website in a Windows Internet Explorer browser window. The address bar shows the URL <http://infoweb/body.cfm?id=1796>. The page has a left-hand navigation menu with the following items: National Patient Safety Goals (NPSGs), Quality and Safety Concerns, VSurvey Access, VSurvey Training Reference Materials, External Links, and Newsletter Archive. The main content area features a prominent blue button labeled 'REPORT AN EVENT >>' which is circled in green. Below this button, a red arrow points from a red text box containing the instruction 'Click here to enter an event'. Further down, under the heading 'Patient Safety Resources', there are three blue underlined links: 'Click here for a brief tutorial on how to submit an incident.', 'Click here for a PDF of a PowerPoint presentation on incident reporting.', and 'Click here for a handout on who, when and how to report an incident.'. A second red arrow points from a red text box labeled 'Event Reporting Tutorial' to the third link. Below these links, a section titled 'If you have questions or' is followed by a bulleted list of contact information for Carolyn Candiello, Susan Fowble, Cate O'Connor-Devlin, and Pain Nurses.

REPORT AN EVENT >>

Click here to enter an event

Event Reporting Tutorial

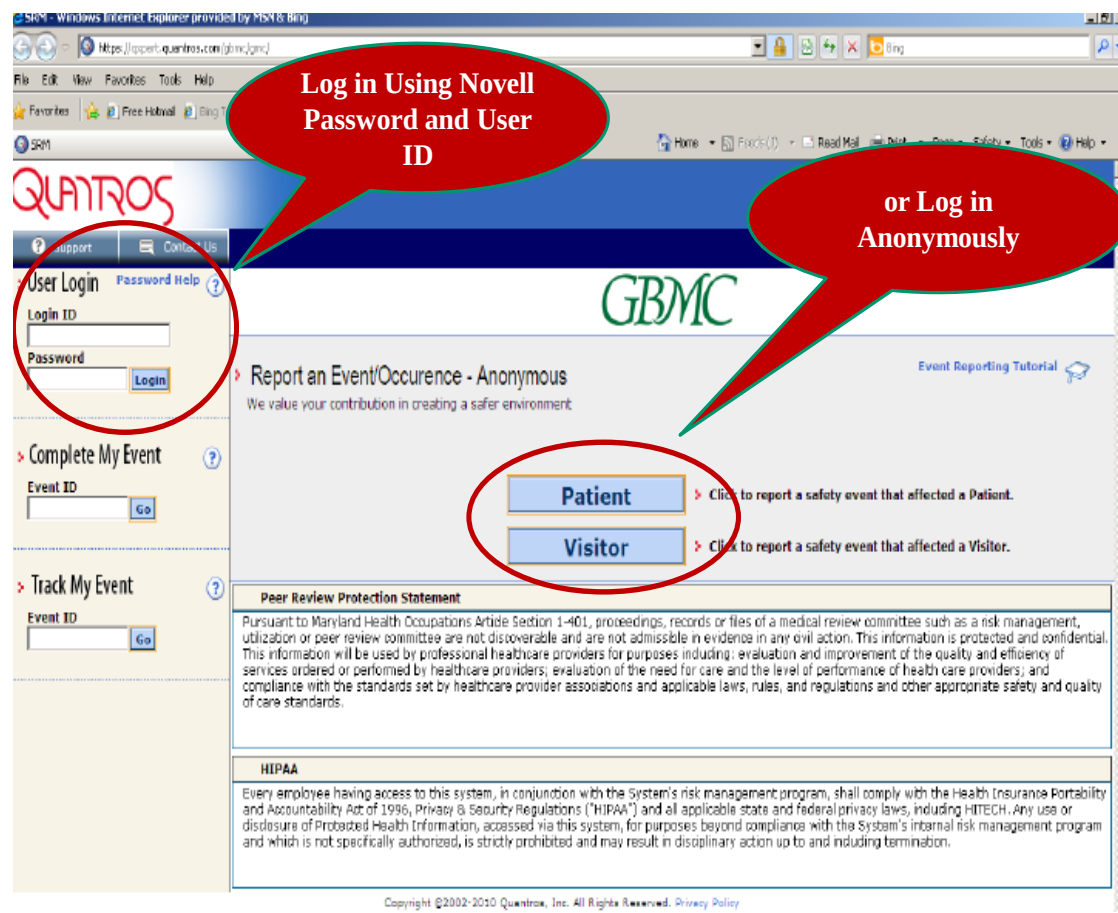
Click here for a brief tutorial on how to submit an incident.

Click here for a PDF of a PowerPoint presentation on incident reporting.

Click here for a handout on who, when and how to report an incident.

If you have questions or

- Carolyn Candiello, VP
- Susan Fowble, Patient Safety Manager: sfowble@gbmc.org x. 3412
- Cate O'Connor-Devlin, Nursing Manager: cconnor@gbmc.org x. 3412
- Pain Nurses: Monday - Friday evenings: x. 6350



Quantros SEM V5.5 - Windows Internet Explorer
https://qxperit.quantros.com/srm/controller/AnonymousSRMController?ServName=QEventAdd&_qc=432d386aaaa167682dd22f4c5f0a7cf9



GBMC - Greater Baltimore Medical Center
6701 N. Charles Street, Baltimore, MD 21204

00:05

Patient Safety Event ID: GJQ5876408 (Anonymous)
Reported by: Anonymous Reporter

Reported on: 01/27/2012 11:45
Occurred on: 01/27/2012



What

* Actual or near miss event? ☒ Actual Event ☐ Near Miss/Close Call

* What happened? [Advanced Search](#)

* Describe what happened (include who was notified and outcome, if known):

Fill out as much as you can. Required fields are marked with an RED ASTERISK (*)

4000 characters left

[Check Spelling](#)

Was any device/equipment involved? ☐ Yes ☐ No [Clear Selection](#)

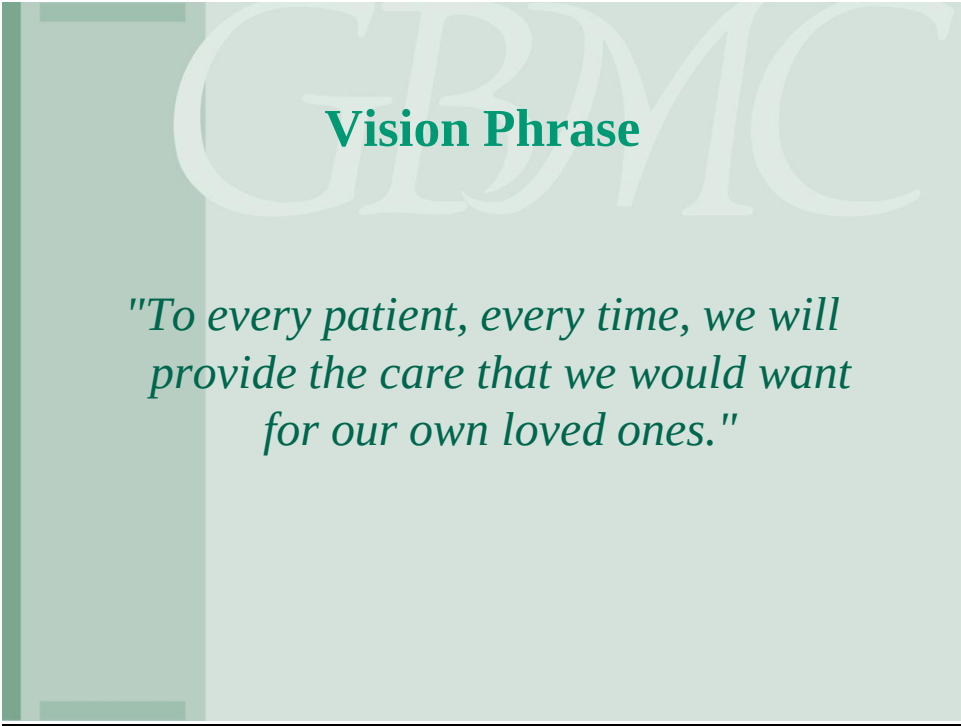
When/Where

* Date/Time of event: ☐ Date unknown
 : ☐ Time unknown

* Department where event occurred:

Other department involved:

External facility involved? ☐ Yes ☐ No [Clear Selection](#)



Vision Phrase

*"To every patient, every time, we will
provide the care that we would want
for our own loved ones."*

In applying for appointment/reappointment, applicants consent to abide by the Bylaws, Rules and Regulations of the Medical Staff and other hospital and administrative policies and guidelines as they presently exist or as amended from time to time. **The following are key policies related to patient safety which are particularly important.**

GBMC Policy	National Patient Safety Goal - Standard #	Standard Text
PATIENT IDENTIFICATION POLICY	NPSG.01.01.01	Use at least two patient identifiers when providing care, treatment and services.
BLOOD RECIPIENT IDENTIFICATION SYSTEM (BLOOD BRACELET): USE OF	NPSG.01.03.01	Eliminate transfusion errors related to patient misidentification.
CRITICAL VALUES REPORTING	NPSG.02.03.01	Report critical results of tests and diagnostic procedures on a timely basis.
LABELING OF MEDICATION	NPSG.03.04.01	Label all medications, medication containers, and other solutions on and off the sterile field in perioperative and other procedural settings. Note: Medication containers include syringes, medicine cups and basins.
ANTICOAGULATION MANAGEMENT	NPSG.03.05.01	Reduce the likelihood of patient harm associated with the use of anticoagulant therapy. Note: This requirement applies only to hospitals that provide anticoagulant therapy and/or long-term anticoagulation prophylaxis (for example, atrial fibrillation) where the clinical expectation is that the patient's laboratory values for coagulation will remain outside normal values. This requirement does not apply to routine situations in which short-term prophylactic anticoagulation is used for venous thrombo-embolism prevention (for example, related to procedures or hospitalization) and the clinical expectation is that the patient's laboratory values for coagulation will remain within, or close to, normal values.
MEDICATION RECONCILIATION	NPSG.03.06.01	Maintain and communicate accurate patient medication information.
INFECTION CONTROL PLAN BBP EXPOSURE CONTROL PLAN	NPSG.07.01.01	Comply with either the current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines or the current World Health Organization (WHO) hand hygiene guidelines.

GBMC Policy	National Patient Safety Goal - Standard #	Standard Text
INFECTION CONTROL PLAN Mandatory MRSA Active Surveillance Testing [AST] in Critical Care Units (continued)	NPSG.07.03.01	Implement evidence-based practices to prevent health care-associated infections due to multidrug-resistant organisms in acute care hospitals. Note: This requirement applies to, but is not limited to, epidemiologically important organism such as methicillin-resistant staphylococcus aureus (MRSA), clostridium difficile (CDI), vancomycin-resistant enterococci (VRE), and multidrug-resistant gram-negative bacteria.
INFECTION CONTROL- SURGICAL SERVICES	NPSG.07.05.01	Implement evidence-based practices for preventing surgical site infections.
INDWELLING URINARY CATHETER REMOVAL STANDING ORDER	NPSG.07.06.01	Implement evidence-based practices to prevent indwelling catheter-associated urinary tract infections (CAUTI). *Note: This NPSG is not applicable to pediatric populations. Research resulting in evidence-based practices was conducted with adults, and there is no consensus that these practices apply to children. Footnote*: Evidence-based guidelines for CAUTI are located at: Compendium of Strategies to Prevent Healthcare-Associated Infections in Acute Care Hospitals at, http://www.shea-online.org/about/compendium.cfm and Guideline for Prevention of Catheter-associated Urinary Tract Infections, 2009 at http://www.cdc.gov/hicpac/cauti/001_cauti.html
SUICIDAL PRECAUTIONS	NPSG.15.01.01	Identify patients at risk for suicide. Note: This requirement applies only to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals.
UNIVERSAL PROTOCOL	UP.01.01.01	Conduct a preprocedure verification process.
UNIVERSAL PROTOCOL	UP.01.02.01	Mark the procedure site.

UNIVERSAL PROTOCOL	UP.01.03.01	A time-out is performed before the procedure.
GBMC Policy	National Patient Safety Goal - Standard #	Standard Text
RESTRAINTS AND SECLUSION	PC.03.03.07	For hospitals that do not use accreditation for deemed status purposes: Staff are competent in minimizing the use of restraint and seclusion for behavioral health purposes and maximizing patient safety when they are used.
	PC.03.03.15	For hospitals that do not use accreditation for deemed status purposes: A licensed independent practitioner sees and evaluates in person the patient who is in restraint or seclusion for behavioral health purposes.
	PC.03.03.19	For hospitals that do not use accreditation for deemed status purposes: Patients who are in restraint or seclusion for behavioral health purposes are reevaluated.
	PC.03.03.23	For hospitals that do not use accreditation for deemed status purposes: Patients in restraint or seclusion for behavioral health purposes are assessed and assisted in meeting criteria for the discontinuation of restraint or seclusion.
	PC.03.03.25	For hospitals that do not use accreditation for deemed status purposes: The hospital monitors patients who are restrained or secluded for behavioral health purposes.
	PC.03.05.01	For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital uses restraint or seclusion only when it can be clinically justified or when warranted by patient behavior that threatens the physical safety of the patient, staff, or others.
	PC.03.05.03	For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital initiates restraint or seclusion based on an individual order.
	PC.03.05.07	For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital monitors patients who are restrained or secluded.
	PC.03.05.11	For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital evaluates and reevaluates the patient who is restrained or secluded.

Please see the following page for the Policies and Procedures Infoweb Screenshot.

[Home](#) → [Policies & Procedures](#) [Print This Page](#) |  [Email to a Friend](#) |    [Font Size](#)

Policies & Procedures

Welcome to the GBMC Policy and Procedures. Use the search tool below to find a specific policy. If you would like to update or submit a new policy, [please click here](#).

Search by Policy

You may search either by the exact policy number, or perform a keyword search within the policy content. Search by Facility/Department/Manual if you would like to retrieve the policies based on which facilities, departments, and/or manuals the policy is in use.

Most Recent Policies within the Last 30 days

This area displays recent policies within the last 30 days based on your preferred facility.

Search by Policy

Policy (keyword match)Policy Number (exact match)Facility Department Manual Next review date falls in Results sorted by ☐ Policy Title ☐ Policy Number ☒ RelevancyNumber of Policies to Display Per Page

Legend:

[SM] system manual indicator

GBMC

CLINICAL POLICY AND PROCEDURE – RESTRAINTS AND SECLUSION

APPROVAL:

Signature on file _____
Sr. VP Patient Care Services & CNO

I. PURPOSE

To provide a consistent, standardized hospital-wide procedure for the assessment, application and evaluation of the use of restraints. To make certain that GBMC uses all alternative measures prior to the use of restraints.

II. DEFINITIONS

A. Restraint: any manual method, physical or mechanical device, materials or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely.

B. Seclusion: the involuntary confinement of a patient alone in a room or area, where the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others.

C. Chemical Restraint: is the use of a medication used to restrict the patient's freedom of movement that is not a standard treatment for the patient's new or continuing medical or behavioral condition. It is this hospital's policy to only use medications that are a standard treatment for the patient's ongoing or newly emerging condition. Therefore, chemical restraint is not used in this institution.

D. Licensed Independent Practitioner (LIP): any individual permitted by law and by GBMC to provide patient care services without direction or supervision, within the scope of his or her license and in accordance with individually granted clinical privileges.

III. POLICY

A. Indications

Restraint or seclusion may be used when less restrictive means would not be effective to protect the physical safety of patients, a staff member, or others. Seclusion may only be used for the management of violent or self destructive behavior that jeopardizes the immediate safety of the patient, a staff member, or others.

1. The standards for restraint use do not apply: when a staff member(s) physically redirects or holds a child, without the child's permission, for 30 minutes or less.

Clinical Policy and Procedure: Restraints and Seclusion
Page 2

B. Restraints may be initiated:

1. Upon the order of a licensed independent practitioner who is responsible for the patient, or
2. By a registered nurse if necessary to protect the patient, staff members or others from harm, provided that an order is immediately obtained from a licensed independent practitioner who is responsible for the patient.

C. Notification of the Attending Physician

If the attending physician is not the person who ordered the restraint, he or she shall be notified by the RN caring for the patient that a restraint was applied by the end of the calendar day.

D. PRN Orders

PRN orders for restraint or seclusion shall not be used.

E. Duration of Restraint / Orders

1. Violent or Self Destructive Behavior (Behavioral Restraint) Orders for restraint or seclusion applied to manage violent or selfdestructive behavior that jeopardizes the immediate safety of the patient, a staff member, or others shall remain in effect until the patient's behavior or situation no longer requires the use of restraint or seclusion, but no longer than:

- a. 4 hours for adults 18 years of age or older
- b. 2 hours for children and adolescents 9 to 17 years of age
- c. 1 hour for children 8 years of age or younger
- d. Renewal orders may be given for the above durations if the indications for restraint or seclusion persist. However, continuation of restraint or seclusion for longer than 24 hours shall be based on an in-person evaluation by a responsible licensed independent practitioner.

2. Medical-Surgical Restraints (Non Violent Behavior) Physician orders for a restraint that is not used for the management of violent or self-destructive behavior shall remain in effect until:

- a. The patient's behavior or situation no longer requires the use of restraint
- b. The end of the calendar day following the date of the order

Clinical Policy and Procedure: Restraints and Seclusion
Page 3

F. Assessment and Monitoring

1. Restraint/seclusion monitoring and assessments shall include elements indicated on the current version of relevant approved forms and templates.

a. Violent Self Destructive Behavior (Behavioral Restraint)

Management of violent or self-destructive behavior that jeopardizes the immediate safety of the patient, a staff member, or others

i. One-hour Face-to-face Assessment: A responsible licensed independent practitioner, Nurse Practitioner or a Physician's Assistant shall perform a face-to-face assessment of the patient's physical and psychological status and sign the order within 1 hour of the initiation of restraint or seclusion. Independent practitioners, Nurse Practitioners or Physician Assistants who perform such assessments shall be educated as specified in Section IV of this policy.

ii. Monitoring: Restrained or secluded patients shall be subject to monitoring by individuals educated according to Section IV of this policy.

iii. Simultaneous Restraint and Seclusion: Patients who are simultaneously restrained and secluded shall be continuously monitored through face-to-face observation by staff members

iv. Restraint or Seclusion Alone: Patients shall be monitored on an ongoing basis by staff members who are stationed nearby the patient. The observations made and data collected during such monitoring shall be documented at least every 15 minutes.

b. Assessment: Assessments by a Registered Nurse or Physician Assistant or evaluations by a responsible Licensed Independent Practitioner shall occur as often as indicated by the plan of care based on the patient's condition, behavior, and environmental considerations but at least once every 60 minutes.

Clinical Policy and Procedure: Restraints and Seclusion

Page 4

G. Medical-Surgical Restraints (Non Violent Behavior)

1. Restraint not used for the management of violent or self-destructive behavior.
 - a. Monitoring and assessments shall occur at least every 2 hours by the RN or unlicensed assistive personnel as designated. Reassessment (observed behavior and alternative measures) for restraint need is documented at least once per shift.

H. Discontinuation

1. Restraint or seclusion shall be discontinued by the Registered Nurse once the behaviors or situation that served as the basis for the restraint are no longer present and the safety of the patient, staff members, or others may be assured through less restrictive means.
2. If a patient in restraints requires continuous restraint for over a 24 hour period, a physician shall conduct a face to face evaluation of the patient to determine whether continuous restraint is appropriate.

I. Care Plan

The restrained or secluded patient's written plan of care shall be modified to address appropriate interventions implemented to assure the patient's safety and encourage the prompt discontinuation of restraint.

J. Monitoring Restraint-related Deaths

Hospital personnel shall promptly contact the quality and patient safety department or the administrative coordinator whenever a patient dies while restrained or within twenty-four hours after being released from restraint; or a patient dies as the result of a restraint-related condition within seven days after restraint removal. Hospital personnel shall maintain a log of all such deaths. The log must be made available to CMS immediately upon request.

K. Emergency Department Patients

If a patient arrives in restraints, they will remain in restraints until evaluated by the ED physician. Document patient arrived in restraints. After evaluation by ED physician, an order must be obtained if the use of restraints is to continue. Appropriate documentation must follow.

L. Training

1. Hospital and Medical Staff Members

Shall receive training in the following subjects as appropriate to assigned duties performed under this policy. Such training shall take place before the new staff member is asked to implement the provisions of this policy and shall be repeated periodically as indicated in the hospital's training plan, which shall be based on the results of quality monitoring activities.

2. Physicians who order restraint or seclusion

- a. Shall be educated in the requirements of this policy.

Clinical Policy and Procedure: Restraints and Seclusion
Page 5

3. Hospital staff members who assess patients for restraint or who apply restraint shall receive training in the following topics as appropriate to the patient population served:

- a. Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of a restraint or seclusion.
- b. The use of nonphysical intervention skills.
- c. Choosing the least restrictive intervention based on an individualized assessment of the patient's medical, or behavioral status or condition.
- d. The safe application and use of all types of restraint or seclusion used by the staff member, including training in how to recognize and respond to signs of physical and psychological distress
- e. Clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary.
- f. Monitoring the physical and psychological well-being of the patient who is restrained or secluded, including but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by hospital policy associated with the 1-hour face-to-face evaluation of patients restrained or secluded for the management of violent or self-destructive behavior.
- g. The use of basic life support and certification in the use of cardiopulmonary resuscitation, including required periodic re-certification.

4. Hospital staff members who monitor restrained patients shall be trained in the recognition of signs of physical and psychological distress, including the signs of asphyxia.

Date Posted on Web: 01/2013

Responsible for Review: CNO

Date Reviewed: 1/2003, 4/2003, 12/2003, 4/2003, 11/2006, 11/2007, 8/2011, 11/2011, 12/2012

Medical/Surgical Restraints (Non-Violent) In Patient Units (ICU and Med/Surg)

A “Medical/Surgical” Restraint is used to ***promote medical healing*** and to prevent the patient from interfering with care, treatment, and services to ***achieve healing***.

Medical/Surgical Criteria Necessitating Restraint:

- Dislodging drains, IV access, dressings
 - Pulling at endotracheal tube
 - Pulling at central vascular access line
 - Interfering with necessary care or treatment
1. RN must obtain an order as soon as possible after initiation of restraint
 2. Restraint order must be renewed every calendar day
 3. Physician must physically see and evaluate the patient on a daily basis to assure restraint is still required
 4. Assessment/Re-assessment in Meditech is required Q2 hour

REQUIRING A PHYSICIANS ORDER

4Bed Rails



(2 pt only)
**Soft Upper
Limb**



Roll Belt



Mittens



Lap Belt



Violent or Self Destructive Behavior Restraint Emergency Dept. and Unit 36

(All other units need to notify their Nurse Manager or AC)

A Restraint for violent or self-destructive behavior is to protect the patient from causing ***imminent harm to self or others***.

Criteria Necessitating Restraint for Violent & Self-Destructive Behavior Include:

- When behavior is NOT driven by an underlying clinical condition
 - When other non-physical interventions are not effective in deescalating the patient's behavior
 - Hostile outbursts threatening safety of self or others
 - Physical bodily threat to self or others
 - Inability to control actions with progressively violent behavior
 - Severe aggression
1. RN must obtain an order as soon as possible after initiation of restraint
 2. Restraint order must be renewed based on age time-limits
 3. Physician must physically see and evaluate the patient within 1 hour of initiation
 4. Re-assessment is required Q15 minutes on paper documentation form

Requiring a Physician's Order

Neoprene Cuffs



Neoprene Hobble



Neoprene Ambulatory belt



Neoprene Ambulatory belt



Seclusion



SURGICAL ORIENTATION

GBMC has 38 operating rooms on-site, located in the three locations, the General Operating Suites (GOR), Virginia Sherwood Surgical Center, and Women's Surgical Center. GBMC staff is eager to make your transition to our surgical world an easy one. You are welcome to join us for a separate orientation.

To Schedule An Orientation: Contact your Physician Relations Representative Bonnie Longerbeam or Ann Veltre to facilitate. Physician Relations main number is 443-849-6176.

Key Contacts: Treve Kosco, RN, GOR 443-849-2138
Mary Knapp, RN, Nurse Manager Sherwood 443-849-8440
Calvin Fletcher, RN, Women's Surgical Center 443-849-8920
Charlene Mahoney, RN GOR PACU 443-849-2250
Roberta Cordara, RN, Scheduling & Pre-Surgical Testing 443-849-3442
MEDITECH Training – Call GBMC Help Desk 443-849-3725

Orientation Includes:

1. Tour
2. Introduction to key staff
3. Locker information
4. Scrub access
5. Access to the area (badge access)
6. Address special equipment needs
7. Posting cases
8. Preference cards
9. Overview of OR Rules and Regulations
10. Address any questions re anesthesiology

Procedures for Medical Attending Daytime Direct Admissions

Purpose: Direct admissions of patients by Medical Attendings or the Hospitalists will be facilitated to provide a safe, comfortable, and efficient admission for the patient and the physician.

This procedure is to be used Monday-Friday 8 a.m. – 6:30 p.m.

1. The physician's office will call Administrative Coordinator at 443-849-2076 to request admission. The following information will be needed:
 - Patient name
 - Admitting Physician Name
 - When was the patient last seen (must be seen by a physician within last 24 hrs)
 - Last set of VS, temp, heart rate, Bp and pulse ox.
 - Date of Birth
 - Diagnosis
 - SSN or Medical Records # (if previous patient at GBMC)
 - Type of bed requested
 - Present location of patient (office, home etc)
 - Estimated time of arrival (if bed available)
 - Condition of patient (ambulatory or wheelchair) and
 - Whether patient will be accompanied by family members that can assist patient to lab or X-Ray (if ordered) or will need GBMC transport assistance.
2. Administrative Coordinator will secure bed and provide the physician's office with bed assignment. (After orders have been received).
3. Physician will write Admission orders and fax the orders to the Administrative Coordinator at 443-849-6933. The orders need to be received prior to the patient arriving.

Labs and X-ray orders should be written STAT.

 - A physician telephone number or pager should be provided on the orders for any questions.
4. The patient should go directly to the Admission Desk in the Main Lobby.
5. Patient will be registered for Admission.

Procedures for Medical Attending Daytime Direct Admissions
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6. The patient's family will be provided with the option to either escort the patient to the lab and/or X-Ray or have GBMC Transport accompany the patient and family.
7. If a transporter is required, Admitting will page the transporter STAT for transportation of the patient.

The transporter will have a Patient Flow Sheet that will list the areas to which the patient is to go and the patient room assignment. The transporter will remain with the patient and expedite the transportation of the patient from designation to designation.

8. The patient chart will be identified with a bright sticker in the top left hand corner to alert staff that this is a direct admit. The Diagnostic Center and Department of Radiology will expedite the care of the direct admit patients.
9. Direct admits will be given priority service in the Diagnostic Center and in the Department of Radiology. In the event that the EKG bed in the Diagnostic Center is occupied, or the patient's condition prevents the EKG from being performed in the Diagnostic Center, this will be noted on the Flow Sheet to alert the RN that the EKG must be performed when the patient arrives on the inpatient unit.
10. Direct admissions will be assigned to the first bed available.
11. In the event that the patient has Department of Radiology orders and is unable to travel to the Department of Radiology, in the Radiology Meditech Comment field the following will be entered "STAT the patient is on the floor."
12. The patient chart will be flagged with the bright sticker designating it as a Direct Admit. When the patient arrives on the unit, the Physician orders will be reviewed immediately by the RN to facilitate patient care.
13. When the patient arrives on the unit, the patient will be seen by the Nurse Practitioner (who will be paged STAT) unless the attending physician writes to the contrary in his/her admitting orders.

Procedures for Medical Attending Direct Late Admissions

Purpose: Direct Late Admissions of patients by Medical Attendings will be facilitated to provide a safe, comfortable, and efficient admission for the patient, their family, and the physician.

This procedure is to be used Monday-Friday 6:30 p.m. – 8:00 a.m. and Saturday and Sunday until 8 a.m. Monday.

1. The physician will call the Administrative Coordinator at 443-849-2000, Beeper 406 to request admission. The following information will be needed:
 - Patient name
 - Admitting Physician Name
 - Date of Birth
 - Diagnosis
 - Type of bed requested
 - Present location of patient (office, home, nursing home, etc)
 - Estimated time of arrival
 - Condition of patient (ambulatory, wheelchair, or ambulance)
 - Whether Hospitalist involvement will be necessary
 - Whether medical Nurse Practitioner involvement is requested. The medical Nurse Practitioners are available until 9:00 pm, Monday through Friday, with the exception of holidays.

2. Administrative Coordinator will secure bed and provide the physician with bed assignment.

The Administrative Coordinator will also notify the Admitting Office if before 10 pm or from 6 am – 8 am the following morning or the Registration Desk in the Emergency Department from 10 pm – 6 am about the patient and the unit to which the patient will be admitted including the estimated arrival time.

3. Physician will write Admission orders and fax the orders to the Administrative Coordinator at 443-849-3425. The orders need to be received prior to the patient arriving. The physician may give the admitting orders to the patient to bring to the hospital and will notify the Administrative Coordinator that the patient will be bringing his/her orders.

Labs and X-ray orders should be written STAT.

- A physician telephone number or pager should be provided on the orders for any questions.

Procedures for Medical Attending Direct Late Admissions

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4. If the physician does not have a fax machine or other methods by which to get the admitting orders to the hospital, the physician must call the Hospitalist (443-849-3135; Pager 398) and request the Hospitalist's involvement in the case which will include an admitting note and admitting orders. As a result of the discussion between the physician and the Hospitalist, the Hospitalist will be responsible for the patient until the attending physician **assumes care of his/her patient at 8 am. The Hospitalist may direct the patient to the Emergency Department for an initial evaluation if needed.** If the patient does proceed directly to the Unit, the Unit will notify the Hospitalist once the patient arrives.

The Hospitalist group will be available to assist in Direct Late admissions from 6 pm to 8 am, Monday through Sunday. During the day (8 am to 6 pm) on Saturday, Sunday, and holidays, the physician will be responsible for the entire direct admission process.

5. If ambulatory, the patient should be directed to the Admissions Desk in the Main Lobby until 10 p.m., after that, the patient should go to the Registration Desk in the Emergency Department until 6 a.m. the following morning and inform the registrar that they are to be directly admitted and be escorted to their room. From 6:00 – 8:00 a.m., the patient should be directed to go directly to the Admission Desk in the main lobby and be escorted to their room.

In the event the patient is being transported by ambulance, the patient should be taken to the Emergency Department and the Clinical Unit Coordinator in the Emergency Department will tell the ambulance team the location of the patient's room.

6. The patient will be registered for admission either at the Admission Desk in the main lobby or at the Registration Desk in the Emergency Department.
7. If a transporter is required, Admitting or the Emergency Department Registration desk will page the transporter STAT for transportation of the patient.
8. Direct admissions will be assigned to the first bed available.
9. When the patient arrives on the unit, the Physician orders will be reviewed immediately by the RN to facilitate patient care. **The admitting RN should contact the physician if in that nurse's judgment, the patient's condition warrants immediate further evaluation.**
10. In the event that the patient needs blood work and the floor nurses are unable to draw the necessary labs, the charge nurse on the floor will call the Administrative Coordinator (beeper 406). If she unable to draw the necessary labs, she will call the charge nurse in the Emergency Department (443-849-6861) who will send a technician to draw the blood at the patient's bedside.

The Joint Commission

- * You have the right to contact The Joint Commission (TJC) with any concern about the **safety or quality of care** provided at GBMC or at any hospital.
- * GBMC cannot take disciplinary action against you for filing a complaint with The Joint Commission.

We would prefer....

- * *That you give us the opportunity to address your concerns*
- * Contact
 - Your manager
 - Your manager's boss
 - Compliance 443-204-8128
 - Quality Assurance 443-849-3807
 - Risk Management 443-849-2514
 - Division Chief, Department Chair or Chief of Staff

Contact Information

- * www.jointcommission.org
 - * E-Mail to complaint@jcaho.org Fax to Office of Quality Monitoring (630) 792-5636
- Print a [Quality Incident Report Form](#)

Compliance and Internal Audit

Compliance Hotline: 1-800-299-7991 (available 24/7; anonymous reporting available)

Compliance

GBMC HealthCare's (GBMC) Board of Directors approved the development of a Corporate Compliance Program in October 1998 to emphasize and enhance GBMC's commitment to business ethics, legal and regulatory compliance. The Compliance Program was developed based on the [seven key elements](#) outlined in the Office of Inspector General's Compliance Program Guidance for Hospitals.

The fundamental mission of the Compliance Program is to ensure that GBMC conducts its business operations with the highest of ethical standards and complies with state and federal regulations.

The Compliance Department is often called upon to facilitate the interpretation of compliance-related rules, provide guidance in setting standards, recommend corrective action where necessary, and ensure that appropriate lines of communication, training, and feedback exist. President and CEO, John B. Chessare, M.D., fully supports all Compliance efforts.

HIPAA

GBMC HealthCare has a HIPAA Privacy and Security plan in place. We take very seriously the protection of our patients' protected health information and follow all state and federal guidelines.

Internal Audit

The purpose, authority, scope, and responsibilities of Internal Audit are outlined in the GBMC HealthCare Board-approved [Internal Audit Charter](#). The Internal Audit Department is often utilized as an independent, objective assurance and consulting mechanism designed to add value and improve an organization's operations. In addition to the GBMC Code of Business Ethics and Standards of Conduct, our department adheres to The Institute of Internal Auditors Code of Ethics regarding the principles and standards we use in carrying out our professional responsibilities to GBMC.

Location

We are located in the South Chapman building on the Campus of the Sheppard Pratt Health System. Our address is 6545 North Charles Street, Suite 201, Baltimore, Maryland 21204.

Contact Us

<u>Stacey McGreevy, CPA</u>	Chief Audit Executive and Compliance Officer & HIPAA Privacy Officer	443-849-4325
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Lisa Sharp, RN	Clinical RAC Coordinator	443-849-6783
Teresa Schorr	Compliance Manager	443-849-2358

<u>Barbara Olsen, CPC</u>	Compliance Auditor	443-849-4316
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Donna Stetka, RN, BSN	Medical Auditor	443-849-4322
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<u>Dan Shelly, CPA</u>	Senior Internal Auditor	443-849-4327
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Voicemail is available for after-hours concerns. You may also email the Compliance Department by sending an email to compliance@gbmc.org. If you would like to place an anonymous call or have an issue that you need to report and are unable to reach anyone in the Compliance Department, please call the **Compliance Hotline 1-800-299-7991**. This line is available 24 hours a day, seven days a week